LIFETIMECHIRO

New Patient Questionnaire

Private & Confidential

Date _____

My purpose for seeking care at this clinic is:

- ☐ Comprehensive health care for myself and my family
- ☐ Comprehensive health care for myself only
- ☐ Relief of my immediate symptoms only

Personal Details

Name _____
First Middle Surname Preferred Name

Date of Birth _____ Age _____

Address _____

Suburb _____ Postcode _____ State _____

Email _____

Mobile _____ Home _____ Work _____

Who recommended you to the practice? _____

Occupation _____ Employer _____

Number of Children _____ Partners Name _____

Emergency contact name: _____ Phone number _____

Previous Chiropractic Care

Name of Chiropractor _____

Last Adjustment Date _____

When were your last X-rays taken? _____ What were the X-rays of? _____

Other Previous Care

Please list below any other forms of treatment you have been under for this complaint

_____

_____

Your Health

What is your main complaint? _____

Duration of above complaint? _____ What caused this? _____

What is your current pain rating? (Please circle 1=No pain 10=severe pain) **1 2 3 4 5 6 7 8 9 10**

List any surgeries or hospital stays from birth till current: (Including medical devices/Implants & Dental work)

_____

_____

List any Injuries or Accidents from birth till current:

_____

_____

Are you currently exercising? YES / NO Please give details

_____

_____

List any medications/supplements you are currently taking

_____

_____

Do you suffer from any conditions? (*please tick*)

	Yes	No
Asthma		
Diabetes		

	Yes	No
Epilepsy		
Stroke		

	Yes	No
Heart Attack		
Other		

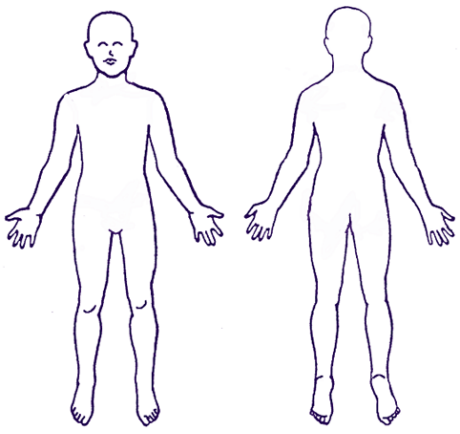
Do you suffer from any of the following? (*please tick*)

	Yes	No
Headaches		
Period Pain		
Chest Pain		
Back Pain/Stiffness		
Sleeping Difficulty		
Shortness of Breath		
Constipation/Diarrhoea		

	Yes	No
Cold Hands/Feet		
Loss of Smell		
Loss of Balance		
Shoulder/Scapula pain		
Can't fight infection		
Numbness /Pins and needles		
Muscle Spasms/Cramps		

	Yes	No
Cold Sweats		
Dizziness		
Fatigue		
Fainting		
Fever		
Neck Pain/Stiffness		
Depression		

Please indicate on diagram below the areas that cause concern



LIFETIMECHIRO

CONSENT FORM

Chiropractic Care, when performed by a qualified Chiropractor has been found to be both an effective and safe form of care for many health conditions. There are, however, risks associated with any treatment no matter how small, that you need to be informed of and we ask that you read the following carefully:

I understand there are very minimal risks resulting from treatment, such as but not limited to: muscle and joint soreness, sprain, muscle strain, disc injury, nerve irritation or damage.

I understand in extremely rare cases, some treatments to the neck may result in injury to blood vessels and give rise to stroke or stroke like symptoms. (approximately 1 in 5.85 million neck adjustment.)

I understand that results are not guaranteed and that consent can be withdrawn at any time.

I give consent, by signing below, to cover the entire course of treatment for my presenting complaint(s), and for any other future condition(s) for which I seek treatment from the below named Chiropractor and any of the registered Chiropractors practicing at Lifetime Wellness at Kenmore.

In the case of chiropractic services being rendered to a minor, or a patient who is recognised to have diminished intellectual capacity, this consent is to be signed by either a parent or legal guardian, this fact being appropriately noted below. I have read or have had read to me the above consent and I have also had an opportunity to ask questions about this consent.

_____	_____	___ / ___ / ___
Patient's Name (PRINTED)	Patient's Signature (Parent or Guardian)	Date
_____	_____	___ / ___ / ___
Chiropractor's Name (PRINTED)	Chiropractor's Signature	Date

876 Moggill Road Kenmore Qld 4069 Ph 07 3878 1553

www.kenmorechiropractic.com.au