



# New Patient Questionnaire

Private & Confidential

- 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: \_\_\_\_\_  
Title                      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: \_\_\_\_\_

## 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any medications/supplements you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

Do you suffer from any conditions? (please tick)

Asthma    Diabetes    Epilepsy    Stroke    Heart Attack    Other: \_\_\_\_\_

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

- Headaches    Shortness of Breath    Numbness /Pins and needles    Cold Hands/Feet    Period Pain
- Neck Pain/Stiffness    Loss of Smell    Cold Sweats    Fatigue    Constipation/Diarrhoea    Sleeping Difficulty
- Back Pain/Stiffness    Depression    Dizziness    Fainting    Fever    Can't fight infection    Chest Pain
- Loss of Balance    Dizziness    Muscle Spasms/Cramps

**Please indicate on diagram below the areas that cause concern.**

