مركز التعافي الطبي
Wellbeing Medical Centre

CHIROPRACTIC NEW PATIENT FORM

Items with * are mandatory as per Dubai Department of Health

Dr./Mr./Ms./Mrs. **Name*** First________________________ Last____________________________

Birthdate*dd/m/yr______________Age_____**Nationality***________________ **Sex/Gender*** __________

Mobile No.* ____________________ **Email***______________________________

PO Box ____________ Address ____

Insurance Co________________ Occupation __________________ No. of children, if any__________

How did you learn about our centre? Please specify

( ) Dr. ______________________________
( ) Patient ___________________________
( ) Magazine __________________________
( ) Other, please specify ____
( ) www.wellbeingmedicalcentre.com
( ) www.mydubaichiropractor.com
( ) Other websites ___________________________

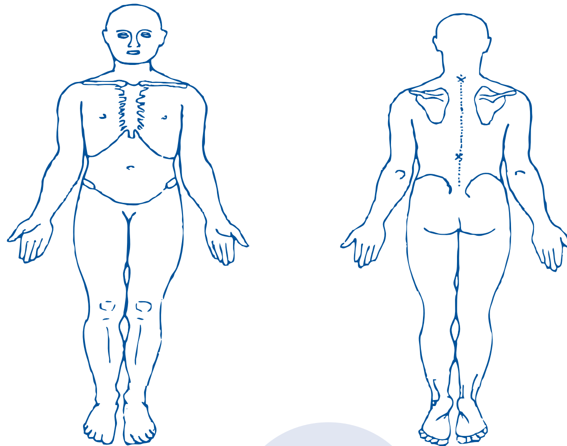
1. *Which of the following is your reason for consultation ?* √ = Primary X = Secondary

( ) Low Back Pain / Stiffness
( ) Neck Pain / Stiffness
( ) Mid-back pain / Stiffness
( ) Headache
( ) Numbness / Tingling
( ) Check up
( ) Shoulder Pain
( ) Elbow Pain
( ) Wrist / Hand Pain
( ) Pelvis / Hip / Groin Pain
( ) Knee Pain
( ) Ankle / Foot Pain
( ) General Arm Pain
( ) General Leg Pain
( ) Dizziness
( ) Sports Performance
( ) Pregnancy
( ) Other ___________________________

Please draw in the area where your symptoms are

X = pain

0 = numbness / tingling



2. *How long have you been experiencing your symptoms ?* ________________________________

3. *How often do you experience your symptoms ?* ______________________________________

4. *On a scale of 1 (mild) to 10 (severe), how bad are your symptoms?*

1 2 3 4 5 6 7 8 9 10

5. *What makes your symptoms better?* ________________________ *worse?*___________________

please turn over

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6. *Have you had these symptoms before ? If so, when ?* ______________________________

7. *Any other health changes in the last 3 months?* ______________________________

8. *Have you seen any doctor about your complaint?* Yes / No

Who______________________ Treatment ______________________________

9. *Are you currently seeing another doctor for other reasons?* Yes/ No

Who ______________________ Treatment ______________________________

10. *Have you ever been to a Chiropractor before?* Yes / No

Who ______________________ When ______________________________

11. *Current Medication / Supplements* ______________________________

12. *Which of the following diseases affect your immediate family?*

( ) High Blood Pressure ( ) Thyroid Problems ( ) Arthritis ( ) Joint Problems
( ) Cancer ( ) Heart Disease ( ) Spinal Problems ( ) Scoliosis
( ) Diabetes ( ) Lung Disease ( ) Nerve Problems ( ) Bone Problems
( ) Other, relevant ______________________

13. *List previous*

a. Fractures / Dislocations / Injuries ______________________________

b. Illnesses ______________________________

c. Operations / Hospitalizations______________________________

d. X-rays and When______________________________

14. Social History:

a. *Do you smoke*? No ________ Yes, how many ? ______________________________

b. *Do you exercise*? No ________ Yes, how often ? ______________________________

d. *Daily Fluid* Water ______ Coffee/Tea _______ Alcohol / Cold drinks______________

Signature______________________________

Date______________________________

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