newstead chiropractic and health

CONFIDENTIAL NEW CLIENT QUESTIONAIRE

Name: _____ Date: _____

Address: _____ Postcode: _____

Telephone (mobile): _____ Email address: _____

Date of Birth: _____/_____/_____ Occupation: _____

Emergency Contact: _____ Ph: _____ Relationship to you: _____

Who or what referred you to our practice: _____

CHIROPRACTIC HISTORY

Have you had previous Chiropractic care: □ Yes □ No When was your last adjustment: _____

Name of previous Chiropractor: _____ Location: _____

Reason for Care: _____

CURRENT CONCERN

What is the reason for todays visit: □ Spinal checkup/wellness evaluation

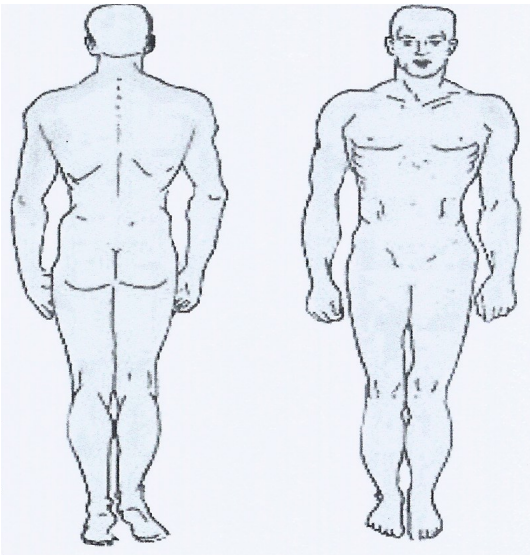
□ I have pain or another symptom (please describe):

_____

_____

_____

Please indicate area(s) of discomfort on the diagram:



Please indicate the severity of discomfort you are experiencing right now:

1 2 3	4 5	6 7 8	9 10
no pain	discomfort	very sore	extreme pain

Does this condition interfere with:
□ Work □ Sleep □ Routine □ Sitting

What makes your symptoms better: _____

_____

What makes your symptoms worse: _____

_____

When did your symptoms start: _____

Days _____Months _____ Years _____

Are they getting worse: □ Yes □ No Has this occurred before: □ Yes □ No

If so, when did it occur: _____ How often: _____

What do you think caused it: _____

Have you received any treatment for this issue, if so, please list: _____

_____ Was it effective: □ Yes □ No

CENERAL HEALTH

List any surgical operations and year they were performed: _____

_____

List any medications/supplements you now take: _____

_____

Have you been in a motor car accident or other trauma:

□ past year □ past 5 years □ over 5years □ never

Describe: _____

Other Health issues & Stresses you have experienced in the last 6mths:

□ Headaches/Migraines	□ Respiratory	□ Skin
□ Double/Blurred Vision	□ Freq. colds/flu	□ Muscle Weakness
□ Dizziness/Loss of Balance	□ Asthma/Problems Breathing	□ Joint Problems
□ Poor Concentration	□ Painful Cough/Sneeze	□ Tingling/Numbness
□ Irritability	□ Heart	□ Fever/Nausea
□ Mood Swings	□ Kidney & Bladder	□ Sleep Disturbance
□ Depression	□ Digestive	□ Increase work stress
□ Anxiety/Panic Attacks	□ Indigestion/Hearthburn	□ Family Problems
□ Low Energy	□ Constipation/Diarrhoea	□ Other: _____

LIFESTYLE

Do you sleep well at night:	_____	How old is your bed:	_____
Do you wear orthotics:	_____	Podiatrist (how long):	_____
Exercise:	_____	Hobbies/sports:	_____
Alcohol – do you drink:	_____	How many per week:	_____
Tobacco – do you smoke:	_____	How many per day:	_____
Appetite/Diet:	_____	Tea/coffee per day:	_____

What lifestyle activities have you had to give up due to your current health condition:

_____

How much do your symptoms effect your life (1= not much – 10=completely): _____

How long since you felt really good (100%): _____ How do you feel now (%): _____

What are your health and lifestyle goals:

Short Term: _____ Long Term: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM