New Patient Form

The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic care and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

DATE: / /

NAME:_____ OCCUPATION:_____

Date of birth: _____/_____/_____ AGE:_____

ADDRESS:_____ POST CODE:_____

PHONE: (H)_____(W)_____ (M)_____

Email:_____

Spouse:_____ Children:_____

Reason for this visit: _____

I am only interested in alleviating my pain Yes____ No____

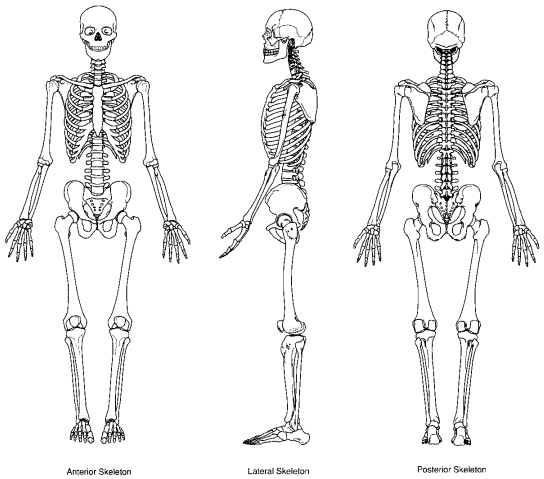
I am interested in resolving the cause of my problem Yes____ No____

Have you received care for this in the past? Yes____ No____

Details of past treatment: _____Family Doctor:_____

How did you hear about us? Referred by _____ Google ____ Local Yellow Pages ____

Melbourne Yellow Pages___ Local Gym ___ Signage____ Newspaper _____ Other_____



Are you on any medication? Y N

Have you had a motor vehicle accident or serious injury? Y N

Have you been admitted to hospital in the past 12 months? Y N

Do you have any xrays, CT scans, MRI, Ultrasound? Y N

Do you have any ongoing health problems? Y N

Have you had any unexplained weight loss? Y N

Have you had any abnormal bleeding from any body part? Y N

Have you had any recent changes in a mole or freckle? Y N

Do you have any unusual lumps or swellings? Y N

MARK AREAS OF COMPLAINT

NOTES:_____

_____

_____

_____

Is this a WorkCover or TAC claim? Y N

(If yes, you will be responsible for payment at each visit. We do not send accounts.)

SYSTEMS REVIEW HISTORY

Please circle Yes or No to the following questions about your general health. This information will give us a more complete understanding about your body's overall function.

Headaches	Y	N	Neck pain	Y	N
Dizziness	Y	N	Neck stiffness	Y	N
Blurred vision	Y	N	Mid back pain	Y	N
Ring / buzz in ears	Y	N	Chest pain	Y	N
Difficulty swallowing	Y	N	Palpitations	Y	N
Loss of consciousness	Y	N	High blood pressure	Y	N
Numbness in any body part	Y	N	Low blood pressure	Y	N
Weakness in any body part	Y	N	Heart trouble	Y	N
Stroke	Y	N	Difficulty breathing	Y	N
Depression	Y	N	Low back pain	Y	N
Nervousness	Y	N	Stomach trouble	Y	N
Sleeping problems	Y	N	Indigestion	Y	N
Energy loss	Y	N	Liver problems	Y	N
Morning tiredness	Y	N	Colon problems	Y	N
Fainting feeling	Y	N	Diabetes	Y	N
Sinus problems	Y	N	Kidney / bladder problems	Y	N
Allergies	Y	N	Poor circulation	Y	N
Female problems	Y	N	Upper limb problems	Y	N
Male problems	Y	N	Lower limb problems	Y	N

Other:_____

_____

Relevant Family History:_____

_____

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

I believe the information above is correct to the best of my knowledge. (Please sign below)

***Cancellations*: We ask that you respect our cancellation policy to ensure we have enough time to contact other clients on our waiting list. 24 hours notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee will be charged.**

Patient's Signature:_____ Date: / /