Tawa Chiropractic New Patient Form

TAWA CHIROPRACTIC
FAMILY HEALTH PRACTICE

Personal Information

Name		**Today's Date**
Address		
Preferred Phone	**Alternative Ph**	**Date of Birth**
Email		**Male / Female** (Pregnant Y / N)
Emergency Contact (& phone)		
GP Name	**Hrs worked/study per week**	**Height (approx.)**
Occupation	**Employer/School**	**Weight (approx.)**
Who or what referred you to Tawa Chiropractic?		

Current Health

Primary reason for consulting our centre

Rate of Severity (mild) 1 2 3 4 5 6 7 8 9 10 (severe) **How long has this been going on?**

How did it begin (gradual or traced to an event)

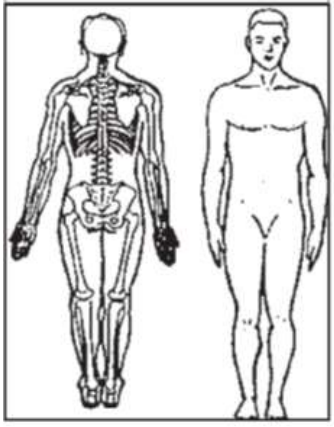
What aggravates it?

What improves it?

What are 3 things you would like to improve your ability to do?

Others seen for this condition

PLEASE MARK AFFECTED AREAS



Main area of Body Pain/Discomfort/Concern

Please circle all appropriate descriptions

Sharp Dull Numb Burning Ache Stiffness

Improving Worsening Same Constant Intermittent

Does the problem radiate anywhere

Other problems you are concerned with

Previous Chiropractic Care (Who/When)

General Lifestyle

Hours per day spent: Sitting/driving ____ Standing ____ Physical Labour ____ Sleeping ____ Other(describe) _____

Sleeping Position Front / Side / Back **Do you use:** Foot Orthotics / Back Support / Orthodontic device (braces/plate)

Exercise Days per week ____ Describe Activities:

Stretching Days per week ____ **Are you your ideal weight** Y / N (if No, what would Ideal be _____)

Water (per day) less 1L / 1L / more 1L **Caffeinated Drinks** (per day) ____ **Alcohol** (per week) ____ **Smoker** (per day) ____

What do you eat for Breakfast? **Particular Dietary/ Intolerances?**

Current Medications/Supplements:
Current or Past Mental or Emotional Issues:

Past History: Please give date & brief description

Automobile accidents (15km/hr or more)
Injuries / falls / fractures / head trauma
Surgery / Operations / Hospital visits / Major Illnesses
Previous Imaging (X-ray, MRI, CT etc)
Family History

General Health History

Please circle **C** if you are currently experiencing or **P** have these symptoms previously:

P	C	Headaches	P	C	Hand/Finger Problems	P	C	Cold sores	P	C	Painful periods
P	C	Spacey	P	C	Heart Disease /Condition	P	C	Low energy	P	C	Premenstrual Syndrome
P	C	Dizziness	P	C	High Blood Pressure	P	C	Nightmares	P	C	Menopause Symptoms
P	C	Memory trouble	P	C	Low Blood Pressure	P	C	Burning feet	P	C	Bedwetting
P	C	Ear Aches	P	C	Fainting Sensation	P	C	Overwhelmed by stress	P	C	Foot/ Toe Problems
P	C	Tinnitus	P	C	Rapid Heart Beat	P	C	Decreased urine output	P	C	Reproductive Disorder
P	C	Vertigo	P	C	Heart Palpitations	P	C	Increased urine output	P	C	Depression
P	C	Nose Bleeds	P	C	Chest pain / tightness	P	C	Swollen ankles	P	C	Migraines
P	C	Sinus trouble	P	C	Asthma	P	C	Puffy Eyelids	P	C	Dyslexia
P	C	Snoring	P	C	Chronic cough	P	C	Kidney/ Bladder Infection	P	C	Epilepsy / Seizures
P	C	Itchy/achy eyes	P	C	Wheezing / Pneumonia	P	C	Bad Breath	P	C	Compulsive disorders
P	C	Allergies	P	C	Gall Bladder Issues	P	C	Flatulence	P	C	Sensitivity to light
P	C	Food Sensitivities	P	C	Bloating after meals	P	C	Dark circles under eyes	P	C	ADD/ ADHD
P	C	Eczema	P	C	Trouble with fatty foods	P	C	Irritable bowel or Crohns	P	C	HIV / AIDS
P	C	Excessive Fatigue	P	C	Heartburn/Indigestion/Reflux	P	C	Abdominal cramps	P	C	Autoimmune disorder
P	C	Anxiety	P	C	Stomach Ulcers	P	C	Constipation	P	C	Cancer
P	C	Shortness of Breath	P	C	Anaemia	P	C	Diarrhoea	P	C	Tremors
P	C	Overactive Thyroid	P	C	Crave sweets	P	C	Coated Tongue	P	C	Stroke
P	C	Nervousness	P	C	Diabetes	P	C	Hemorrhoids			

I have filled in this form to the best of my knowledge. I understand that no accounts are rendered at Tawa Chiropractic & the fee for service rendered is due at time of service. For ACC clients: I understand that if my claim is not accepted that I am liable for the outstanding charges. I consent to the use & disclosure of my personal information by Tawa Chiropractic to other health professionals who are involved in my health care.

I hereby give consent to undergo a new patient consultation &/or examination.

Sign _____ Print Name _____ Date_____