NEW PATIENT QUESTIONNAIRE

(STRICTLY CONFIDENTIAL)

ADULT **Date: _____**

Personal Details

Mr/Mrs/Miss/Ms_____

FIRST NAME **MIDDLE NAME** **SURNAME**

Address: _____

_____ Post Code _____

Telephone: (Home) _____ (Mobile) _____

(Work) _____ (Email) _____

Date of Birth: / / Age: ____ Number of Children: ____ Partners Name: _____

Occupation: _____Health Fund: _____

Referral Details

Who can we thank for referring you to us:

Family/ Friend (name) _____ ❑ Chiropractic Association

❑ Health Fund ❑ Health Care Practitioners ❑ Internet ❑ Saw Signage

Accidents or Injuries

List any accidents or injuries:

	*D*ate		Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Medical Doctor is: _____ Phone Number: _____

Health Details

Tick which medication/s currently taken: ❑ Pain Killers ❑ Muscle Relaxants

❑ Anti- Inflammatory ❑ Birth Control ❑ Blood Pressure ❑ Vitamins

Please list any other/s not mentioned above: _____

List any Operations:

	Date		Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Known medical conditions and/or allergies (if any):

_____

_____

Our purpose is to educate and adjust as many families as possible towards optimal health through natural chiropractic care.

Do you suffer from any of the following:

❑ Headaches	❑ Shortness of Breath	❑ Numbness in Arms/Hands
❑ Neck Pain/ Stiffness	❑ Loss of Smell	❑ Cold Hands/Feet
❑ Back Pain/ Stiffness	❑ Period Pain	❑ Cold Sweats
❑ Fatigue	❑ Constipation/ Diarrhoea	❑ Dizziness
❑ Depression	❑ Fainting	❑ Sleeping difficulty
❑ Fever	❑ Chest pain	❑ Can't fight infections

Which of the above is the main reason you have consulted this practice: _____

What was the cause: _____

When did the problem commence: _____

Is the problem: ❑ Getting Worse ❑ Staying the Same ❑ Getting Better

Have you had a similar case before: ❑ Yes ❑ No

Does it interfere with: ❑ Sport ❑ Home ❑ Sleep ❑ Recreation ❑ Work

Have you previously seen a chiropractor:

❑ Yes (Who) _____ Date:_____

❑ No

If yes was it for a similar condition:

❑ Yes

❑ No

Have you seen any other health professional about this problem:

❑ Yes (Who) _____ Date: _____

❑ No

Exercise/ Sports Activities

Please outline any exercises or sports that you are currently participating in:

_____

_____

_____

_____

Is there anything else you would like to tell us:

_____

_____

_____

_____