

# New Patient Information

**Welcome to our office. Please complete all questions**

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Dr/Mr/Mrs/Ms/Miss

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Work Cover: Yes  No

Marital Status: Single  Married  Partner  Divorced  Widowed

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female

Occupation: \_\_\_\_\_

Children's Names and Ages: \_\_\_\_\_

Medicare No: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Reference Number: \_\_\_\_\_

Private Health Fund: Yes  No  Chiropractic Coverage: Yes  No

Who may we thank for referring you / how did you hear about us?: \_\_\_\_\_

Have you been to a chiropractor before: Yes  No

If yes, who? \_\_\_\_\_ When was your last adjustment?: \_\_\_\_\_

Are you consulting our office for: A wellness evaluation  or Specific spinal health concern

Please describe your spinal / health concerns or reasons for consulting our office:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What are the above spine / health concerns stopping you from doing?: \_\_\_\_\_

Is your primary objective: Short term relief  Correct the cause of the symptoms

Medications you are currently taking: \_\_\_\_\_

List and date all accidents and injuries: \_\_\_\_\_

Is there any chance you may be pregnant?: Yes  No

Please tick (✓) any of the following symptoms you have experienced at any time in the past

General	
Cancer	
Convulsions	
Depression	
Diabetes	
Difficulty Sleeping	
Dizziness	
Fatigue	
Headaches	
Nervousness	
Recurrent Flu/ Colds	

Muscle and Joint	
Arthritis	
Hip Pain	
Low Back Pain	
Muscle Spasm	
Neck Pain	
Neck Stiffness	
Pain Between Shoulder Blades	
Shoulder Tension	
Spinal Curvature	
Tension & Irritability	

Gastro Intestinal	
Bloating	
Constipation	
Diarrhoea	
Digestive Problems	
Gallbladder Trouble	
Haemorrhoids	
Indigestion	
Irritable Bowel	
Nausea/Vomiting	
Stomach Pain	

Women Only	
Breast Lumps	
Excessive Menstrual Flow	
Irregular Cycle	
Menopausal Symptoms	
Painful Menstruation	
Pre-Menstrual Tension	
Reproductive Problems	

Eyes, Ears, Nose & Throat	
Allergies	
Ear Ache	
Ear Noises	
Eye Pain	
Hay Fever	
Sinus	
Sore Throat	

Pain or Numbness In:	
Arms	
Elbows	
Feet	
Hands	
Hips	
Knees	
Legs	

Respiratory	
Asthma	
Chest Pain	
Chronic Cough	
Difficulty Breathing	

Cardiovascular	
High Blood Pressure	
Low Blood Pressure	
Poor Circulation	
Varicose Veins	

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_