New Patient Information
Welcome to our office. Please complete all questions

Today's Date: _____

First Name: _____ Surname: _____Dr/Mr/Mrs/Ms/Miss

Address: _____Post Code: _____

Home Phone: _____ Work:_____ Mobile: _____

Email Address: _____

WorkCover: Yes □ No □

Marital Status: Single □ Married □ Partner □ Divorced □ Widowed □

Date of Birth: _____ Age: _____ Sex: Male □ Female □

Occupation: _____

Children's Names and Ages: _____

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. _____

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

_____

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

Medications you are currently taking: _____

_____

List and date all accidents and injuries: _____

_____

Please list any operation you have had:_____

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 & 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: ___/___/___