TheChiro
We've got your back

New Patient Health History Form

Date _____

(A) PERSONAL DETAILS

Last name _____ Mr Mast Dr Miss Mrs Ms First name _____ Preferred name _____

Address _____ Suburb _____ Occupation _____

Phone: Hm _____ Wk _____ Mob _____

Date of birth _____ Age _____ Referred/recommended by? _____

Email: _____ Gender _____ Partners name _____

Would you like to receive our monthly newsletter with news and advice? Yes please No thanks

(B) CURRENT HEALTH

Do you have a main complaint? (if not, move to Section C) – Please describe **where** it is and **illustrate** (below) _____

How did this begin? _____

When did this begin? _____

What does it **feel** like (eg dull ache or sharp pain?) _____

Is it there constantly **or** intermittently? _____

Have you been **treated** for this condition? (If so, by whom?)

Have you had this **before**? _____

What **relieves** the pain? _____

What **aggravates** the pain? _____

Does the **pain radiate** (eg down the arm/leg)? _____

Is there any associated **numbness** or **tingling**? _____

When do you most notice the pain? _____

How severe is the pain? (please **circle**)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Please mark your areas of pain on the figures by indicating the location of pain and the symbol that best describes your discomfort:

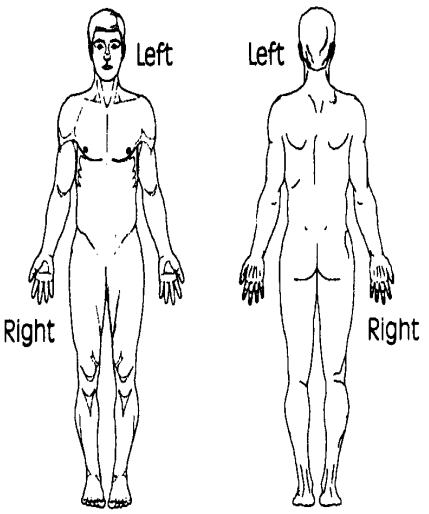
Sharp and stabbing ×

Dull ache ·

Tingling ∴

Numbness •

Stiffness Δ



HEALTH GOALS

What is this stopping you from doing? _____

What specific goals would you like to achieve with chiropractic care? _____

What sport or exercise are you doing currently?

(C) CHIROPRACTIC HISTORY

Previous chiropractor: _____ Where _____ When: _____ to _____

Frequency _____ What was your major reason for attending? _____

If you stopped, why? _____ Other chiropractors? _____

How do you rate the service you received? ☐ Excellent ☐ Good ☐ Satisfactory ☐ Unsatisfactory

PTO

(D) MEDICAL HISTORY

Are you currently taking any prescription or over-the-counter drugs? What? What for? _____

Are you or have you ever been a smoker?

Have you ever been hospitalised or had any operations? What for? When? _____

Have you ever had any major illness/disease? What? When? _____

Name of GP Where Are there any health issues in your family?

When and where were your last spinal x-rays taken?

Do you have, or have you ever had, any of the following? Please tick the appropriate box

Current or Past		Current or Past		Current or Past	
☐	☐ Cancer	☐	☐ Epilepsy	☐	☐ Fractured ribs/pelvis/ vertebrae
☐	☐ Neck brace	☐	☐ Neck pain	☐	☐ Tension across top of shoulders
☐	☐ Disc prolapse	☐	☐ Mid back pain	☐	☐ Numbness of arms/hands
☐	☐ Osteoporosis	☐	☐ Low back pain	☐	☐ Tingling of arms/hands
☐	☐ Balance problems	☐	☐ Sciatica	☐	☐ Numbness of legs/feet
☐	☐ Dizziness	☐	☐ Weakness	☐	☐ Tingling of legs/feet
☐	☐ Stroke	☐	☐ Poor circulation	☐	☐ Headaches
☐	☐ Heart attack	☐	☐ Constipation	☐	☐ Migraines
☐	☐ Asthma	☐	☐ Diarrhoea	☐	☐ Tinnitus
☐	☐ Rheumatoid arthritis	☐	☐ Ulcers	☐	☐ Low blood pressure
☐	☐ Diabetes	☐	☐ Painful joints	☐	☐ High blood pressure
☐	☐ Menopause	☐	☐ Swollen joints	☐	☐ Digestive problems
☐	☐ Irregular periods	☐	☐ Depression	☐	☐ Dermatitis/Eczema
☐	☐ Painful periods	☐	☐ Anxiety/panic attacks	☐	☐ Allergies
☐	☐ Fatigue/Lethargy	☐	☐ Difficulty sleeping	☐	☐ Prolonged cold
☐	☐ Restless legs	☐	☐ Nausea	☐	☐ Sinus problems

(E) SIGNIFICANT ACCIDENTS AND INJURIES

Significant motor vehicle accident (please circle)

1. Head on/nose to tail/side on/rear-ended Your speed? ___ km/hr Speed of other vehicle? ___ km/hr When? _____
Injuries/symptoms? _____

2. Head on/nose to tail/side on/rear-ended Your speed? ___ km/hr Speed of other vehicle? ___ km/hr When? _____
Injuries/symptoms?

Please list any other significant accidents/injuries you have had in your life?

1. What/how? _____ When? _____

Injuries/symptoms? _____

2. What/how? _____ When? _____

Injuries/symptoms?

(G) SIGNATURE

I have filled in this form to the best of my knowledge and I request a chiropractic examination of my whole spine. I consent to the use and disclosure of my personal information by The Chiro to other health providers who are directly or indirectly involved in my health care.

Signature _____ Date _____

Women only: To the best of my knowledge I am not pregnant. Signature _____

Official

X-rays taken: _____ *ACC:* _____

Adjusted: _____ *Next visit:* _____