New Patient Registration Form

Personal Details

Name : _____ _____ _____ _____
Title *First* *Last* *Preferred Name*

Address : _____ _____ _____ _____
Suburb *State* *Postcode*

Phone Numbers : _____ _____ _____
Home *Mobile* *Work*

Email Address : _____

Date of Birth : _____ Age :____ Sex :___ Married( ) Single( ) Divorced( ) Widowed( ) Defacto( ) Separated( )

Emergency contact: _____ _____ _____
Name *Relationship* *Contact Number*

Your Occupation : _____ Employer / School : _____

Medicare Number : _____ Position : _____ Expiry : _____

GP Name and Address : _____

Private Health Cover : ___ **Y /** ___ **N** Name of Fund : _____

Is your chiropractic care covered by DVA or EPC? ___ **Y /** ___ **N** (If yes, please present your referral form to us)

Whom may we thank for referring you to Capital Chiropractic Centre? _____

If not through personal or GP referral, how did you find us? _____

Previous Chiropractic Experience

Name of Chiropractor : _____ How many adjustments did you have? _____

What were you being seen for? _____

Were you satisfied with your care? If not, why? _____

How Can We Help You?

What is the main reason for attending this practice? _____

If you are already experiencing symptoms, what is it? Please list your health concerns below, list WORST first)

Health Concerns (List worst first)	Severity 1=mild 10=unbearable	When did this episode start?	Did you have this condition before?	Started with an injury?	Constant? Intermittent?

Refering to your WORST problem:
→ Describe what kind of pain are you having numbness tingling stiffness dull aching cramping shooting burning stabbing sharp throbbing swelling other : _____

→ Since your problem started, is it : ___ About the same ___ Getting Better ___ Getting Worse

→ What makes it worse? _____

→ What makes it better? _____

→List any previous diagnosis and care you had for this problem : _____

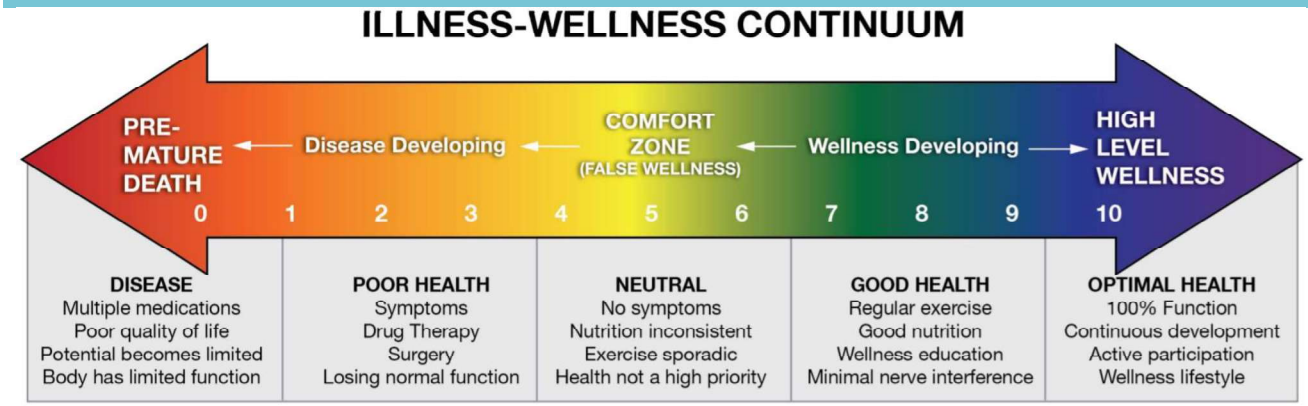
Impact Of Your Symptoms

How is this symptom /condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work					Lifting				
Exercise					Sitting				
Relationships					Standing				
Sleep					Walking				
Self-care (washing, dressing)					Travel (driving)				
Energy					Other				

How committed are you to correcting this issue? (0 = not committed, 10 = very committed) _____

Patient Wellness Assessment



On the arrow diagram above:

→ What number do you think represents your health today? _____

→ In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE : _____

SHORT TERM : _____

LONG TERM : _____

Health History

List any medications, health supplements or recreational drugs that you have used recently : _____

List any surgical operations or hospital stays: _____

Do you / Have you ever suffered from the following:

___ Allergies	___ Digestive issues	___ Jaw (TMJ) issues	___ Reproductive issues
___ Arthritis (_____)	___ Dizziness	___ Kidney disease	___ Ringing in ears
___ Anxiety	___ DVT	___ Knee/foot/ankle issues	___ **Scoliosis**
___ Asthma	___ Elbow/Wrist/Hand issues	___ Loss of vision	___ Shoulder issues
___ Back pain	___ Fracture/dislocation	___ Lymphatic issues	___ Spondylolisthesis
___ Blood pressure issue	___ Gout	___ Migraines	___ Stroke
___ Bone/joint infection	___ Headaches	___ Multiple Sclerosis	___ Thyroid issue
___ Cancer	___ Heart disease	___ Neck pain	___ Urinary issue
___ Depression	___ Hip issues	___ Numbness in the face	Other : _____
___ Diabetes	___ Immune issues	___ Osteoporosis	_____

Is there a family history of the above? _____

Client Consent

To the best of my knowledge, the above is a true and accurate history
I consent to undergo a professional and complete chiropractic examination.
I understand my financial obligations regarding this examination and payment is expected at time of service.

Print Patient Name : _____ Signature: _____ Date: _____