CONFIDENTIAL NEW PATIENT FORM

Please complete all areas of the form, and where not applicable, please state (N/A) or put a dash in the answer space provided. If being completed by a parent or guardian, please state your name when signing the form.

Name:	
Address:	
Phone (Home):	Phone (Work):
Mobile:	Email:
Date of Birth:	No of children/ages:
Occupation:	Who recommended us to you?

What is your major complaint?	
	Pain level 0-10 (10 being worst pain imaginable)
When did this present complaint start?	Has it occurred previously?
Is your complaint: Continuous / On and Off / Nether	
What was the cause of the complaint?	
Have you sought treatment for this complaint? If so, who from?	
List all medication and supplements you are currently taking:	
What aggravates your complaint?	
What alleviates your complaint?	
List any health tests carried out in the past year (i.e. blood test, x-rays etc):	
List all surgical operations you have had, what surgery and when:	
Have you received treatment from a Chiropractor before? Who and when?	
How frequent are your dental visits?	If you have dentures, how old are the current set?
Have you had: toothache / dental emergency / complete dentures / partial dentures	
Do you wear arch supports, orthotics etc? If so, who fitted and when?	
Please list any other significant problems:	
Have you ever had cancer? If yes, when did it occur?	Type of cancer:
Does pain wake you up from sound sleep?	Is this the same every night?
Are you losing weight without trying?	
Are you coughing up blood, or notice blood in stool or urine?	
Have you had any loss of bowel or bladder control?	

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BEING, 22 Nile Street West, Nelson
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Have you lost consciousness or had double vision recently?
Are you seeing any other doctor now for any reason?
Is there are chance you could be pregnant now?

Have you ever: (if yes, please briefly describe)

Been knocked unconscious?
Been hospitalised other than surgery?
Used a cane, crutch or other support?
Been treated for a spine/nervous disorder?
Had a fractured bone?

Do you:

Take vitamins or herbs?
Have an allergy to any drug?

Habits:

Alcohol – heavy / moderate / light / none	Tobacco – No. of cigarettes per day:
Sleep – No. of hours:	Is sleep – sound / light / unsettled / unrefreshing
Exercise:	Drugs:

Treatment Goals:

What is your short term goal of care? (The next week)
Medium term goal of care? (1-3 months)
Long term health goad? (1-5 years)
What would make this experience positive for you? (1-5 years out) i.e: 'play with grandkids, run a mile pain free':
Is today's visit an ACC related complaint?
Please include any other relevant information:

The above information is to the best of my knowledge correct and I have not omitted anything about my health.

Signed:	Date: / /
Parent/Guardians Name:	

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ADDITIONAL HEALTH QUESTIONS

Have you ever suffered from any of the following? Tick the left box for symptoms and conditions you have experienced in the past, and the right for any that you suffer from now. Leave BLANK any that are **not applicable.**

		Past	Now		Past	Now		Past	Now
General	Chills	○	○	Convulsion	○	○	Dizziness	○	○
	Fainting	○	○	Fatigue	○	○	Fever	○	○
	Poor Sleep	○	○	Loss of weight	○	○	Depression	○	○
	Anxiety	○	○	Sweats	○	○	Tremors	○	○
Head/Neck	Thyroid	○	○	Goiter	○	○	Enlarged Glands	○	○
	Eye Pain	○	○	Nose Bleeds	○	○	Eyesight	○	○
	Ear Noises	○	○	Skin Problems	○	○	Migraines	○	○
Structural	Arthritis	○	○	Bursitis	○	○	Foot Trouble	○	○
	Low Back Pain	○	○	Chest Pain	○	○	Neck Pain	○	○
	Upper Back Pain	○	○	Headaches	○	○	Sciatica	○	○
	Swollen Joints	○	○	Poor Posture	○	○	Hernia	○	○
Pain or Numbness in:		○	○	Shoulders	○	○	Arms	○	○
	Elbows	○	○	Hands	○	○	Hips	○	○
	Legs	○	○	Knees	○	○	Feet	○	○
Respiratory	Asthma	○	○	Colds	○	○	Earache	○	○
	Nasal Problems	○	○	Sinus	○	○	Tonsils/Throat	○	○
	Cough	○	○	Wheeze	○	○	Lung Problems	○	○
	Breathing difficulties	○	○						
Gastro/Intestinal	Gas/wind	○	○	Bloating	○	○	Colitis	○	○
	Constipation	○	○	Diarrhea	○	○	Difficult Digestion	○	○
	Hunger	○	○	Gall-Bladder	○	○	Haemorrhoids	○	○
	Jaundice	○	○	Liver	○	○	Nausea	○	○
	Stomach Pain	○	○	Vomiting	○	○	Indigestion	○	○
Cardio-Vascular	High Blood Pressure	○	○	Low Blood Pressure	○	○	Heart Pain	○	○
	Rapid Heartbeat	○	○	Varicose Veins	○	○	Swollen Ankles	○	○
	Hardening of Arteries	○	○	Bruise Easily	○	○	Poor Circulation	○	○
Genito Urinary	Bedwetting	○	○	Infections	○	○	Painful Urination	○	○
	Frequent Urination	○	○	Incontinence	○	○	Kidney/Bladder Stones	○	○
	Prostrate Trouble	○	○	Pus in Urine	○	○			
Women Only	Cramps/Backache	○	○	Excessive Flow	○	○	Hot Flushes	○	○
	Irregular Cycle	○	○	Lumps in Breast	○	○	Menopause	○	○
	Menstrual Pain	○	○	Thrush	○	○	Premenstrual Tension	○	○
Skin	Acne	○	○	Eczema	○	○	Dermatitis	○	○
	Psoriasis	○	○	Hives	○	○	Allergic Rashes	○	○
	Cold Sores	○	○	Mouth Ulcers	○	○	Other	○	○
Allergies	Hives	○	○	Sinusitis	○	○	Iritis	○	○
	Asthma	○	○	Hayfever	○	○	Foods	○	○
	Skin	○	○	Itchiness	○	○	Other Allergies	○	○
	Athletes Foot	○	○						

Please tick the following conditions you have had:

Anemia	○	Arthritis	○	Cancer	○	Diabetes	○	Diphtheria	○	Emphysema	○
Epilepsy	○	Goiter	○	Gout	○	Heart Disease	○	Malaria	○	Measles	○
Miscarriage	○	Mumps	○	Pleurisy	○	Pneumonia	○	Polio	○	Multiple Sclerosis	○
Stroke	○	Tuberculosis	○	Ulcers	○	HIV/Aids	○	Scarlet Fever	○	Rheumatic Fever	○
Hepatitis A	○	Hepatitis B	○	Hepatitis C	○					Other confidential	○

INFORMED CONSENT FORM

Full Name: _____

Address: _____

Date of Birth: _____

PATIENT INFORMATION

Changes in law now require all practitioners who manipulate the spine to warn patients of material risk. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke-like symptoms (approximately 1 in 5.85 million neck manipulations. Haldeman, et al. Spine vol.24-8 1999).

Other very slight risks include strain/sprain to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). (Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.)

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Magna Report, Ontario Ministry of Health, 1993).

If you have any questions related to the treatment you are about to receive, please ask the Chiropractor before commencing treatment.

DECLARATION

In signing this form, I agree that I have read and understood the above information. That I have discussed the above information with the Chiropractor, and that he/she has explained and answered any areas of the above information that I did not understand or had questions about. By signing this form, I give my consent to care.

In addition, I give my consent to the Chiropractor to access and acquire copies of any relevant information from other healthcare professionals, and to discuss my case where necessary with other relevant healthcare professionals.

Patient's Signature: _____ Date: _____

I also understand that Evolving Healthcare has the right to charge a fee, not exceeding the normal consultation charge, for a missed appointment or cancellation with less than 24 hours' notice.

Patient's Signature: _____ Date: _____

Chiropractor's Signature: _____ Date: _____

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