Confidential New Patient Form

Please fill out all areas of these forms, and where not applicable please state (N/A), or put a dash (-) in the answer space provided. If being filled out by a parent or guardian, please state your name when signing the end.

Patient Details

Name: _____ Date: _____
Postal Address: _____
Phone Number: _____ Email Address: _____
Date of Birth: _____ No. of Children and Ages: _____
Occupation: _____ Who recommended us to you: _____

Current Complaints

What is your major complaint? _____
What was the cause of the complaint? _____
When did this complaint start? _____ Has it occurred previously? _____
Pain Level 0-10 (10 being worst pain imagined) _____ Is your complaint: Continuous / Off and On / Neither
What aggravates your complaint? _____
What alleviates your complaint? _____
Have pain or numbness in? (circle any that apply) → shoulders, arms, elbow, hands, hips, legs, knees, feet
Have you sought treatment for this complaint? _____If so from whom? _____
List all medication you are taking at present _____
_____
List all supplements, vitamins, minerals or herbs _____
_____
Do you have an allergy to any drug? _____
List any other significant problems _____

Past Medical History

Health tests in the past year (i.e. blood test, x-rays, etc) _____
Are you taking any Exogenous hormones? (Oral contraceptives, Estrogen, Testosterone, IVF treatments)
_____
Surgical Operations ever had and when_____
_____
_____
Do you wear arch supports, orthotics etc? _____ Who fitted them and when? _____
Have you received treatment from a chiropractor before? _____ Who and when? _____
Are you seeing any other doctor now for any reason? _____
Is there a chance that you are pregnant? _____

Have you ever (If 'yes' then describe briefly)

Been knocked unconscious? _____

Been hospitalised other than surgery? _____

Used a cane, crutch or other support? _____

Been treated for a spine/nerve disorder? _____

Had a fractured bone? _____

Does pain wake you up from a sound sleep? _____ Is this the same every night? _____

Are you losing weight now without trying? _____

Are you coughing up blood or do you notice blood in your stool or urine? _____

Have you had any loss of bowel or bladder control? _____

Have you lost consciousness or had double vision recently? _____

What Dietary lifestyle do you currently follow? (If a child, what is the parent's dietary lifestyle)

Vegetarian ○ Paleo ○ Keto ○ Vegan ○ Other ○ None ○

Habits

Alcohol – heavy / moderate / light / none

Sleep – number of hours _____

Exercise _____

Tobacco – no. of cigarettes per day _____

Is sleep – sound / light / unsettled / unrefreshing

Drugs _____

Treatment Goals

What is your short-term goal? (within the next few weeks)

What is your medium-term goal? (within the next few months)

What is your long-term goal? (within the next year or two)

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 _____

ADDITIONAL HEALTH QUESTIONS

Have you ever suffered from any of the following? Please circle any that apply

Anemia	Arthritis	Cancer	
Anxiety	Asthma	Colitis	
Convulsion	Heart disease	Mumps	Thrush
Depression	Hepatitis A B C	Nausea	Thyroid condition
Dermatitis	Hernia	Pleurisy	Tinnitus
Diabetes	High blood pressure	Pneumonia	Tremors
Diphtheria	HIV/aids	Polio	Tuberculosis
Eczema	Hives	Prostate conditions	Ulcers
Emphysema	IBS condition	Psoriasis	Varicose veins
Epilepsy	Infections	Rheumatic fever	Vertigo
Frequent/painful	Malaria	Scarlet fever	Vomiting
urination	Measles	Shortness of breath	
Gout	Migraines	Sinusitis	
Hay fever	Multiple sclerosis	Stroke	

Have you suffered from any of the following conditions? Please circle any that apply

Alpha 1 – Antitrypsin deficiency	Granulomatosis with polyangiitis	Polycystic kidney disease
Celiac disease	Kawasaki disease	Rheumatoid arthritis
Crohn's	Loeys-Dietz Syndrome	Sarcoidosis
Eosinophilic	Lupus	Ulcerative Colitis
Fibromuscular Dysplasia	Marfan Syndrome	Vascular Ehler-Danlos Syndrome
Granulomatosis	Polyarthritis Nodosa	

Have you had your Plasma Homocysteine levels tested? _____

If so, what is your level? _____>12 µmol/L or _____<12 µmol/L

If you have circled any above, please add additional information (i.e. when, diagnosis date, current or past, etc)

_____
_____
_____
_____
_____
_____
_____
_____