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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.

Name: _____
Postal Address: _____
_____
Phone (home): _____ Phone (work): _____
Mobile: _____ Email Address: _____
Date of Birth:_____/_____/_____ No. of Children and Ages: _____
Occupation: _____ Who Recommended Us to You: _____

What is your major complaint? _____
_____Pain Level 0-10 (10 being worst pain imagined) _____
When did this present complaint start? _____ Has it occurred previously? _____
Is your complaint….. Continuous / Off and On / Neither
What was the cause of the complaint? _____
List all medication and supplements you are taking at present _____
_____
Have you sought treatment for this complaint? _____If so from whom? _____
What aggravates your complaint? _____
What alleviates your complaint? _____
List any health test 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? _____
Do you wear arch supports, orthotics etc? _____ Who fitted them 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 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? _____
Are you seeing any other doctor now for any reason? _____
Is there a chance that you are pregnant now? _____

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? _____

Do you:

Take vitamins, minerals or herbs? _____

Have an allergy to any drug? _____

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

Tobacco – no. of cigarettes per day _____

Sleep – number of hours _____

Is sleep – sound / light / unsettled / unrefreshing

Exercise _____

Drugs _____

Treatment Goals:

What is your short term goal of care? (The next week) _____

What would make this experience positive for you? (1-5 years out) i.e. "play with grandkids" "run a mile pain free" _____

Have you ever received ACC for any personal injury? _____ If so when? _____

What was the nature of the injury? _____

Is today's visit an ACC related complaint? _____

Have you been diagnosed with Fibromuscular Dysplasia? _____

Have you been diagnosed with Marfan Syndrome, Loeys-Dietz Syndrome, Vascular Ehlers-Danlos Syndrome, Alpha 1- Antitrypsin deficiency, or Polycystic kidney disease? _____

Are you taking any Exogenous hormones? (Oral contraceptives, Estrogen, Testosterone, IVF treatments) _____

Have you been diagnosed with a systemic Inflammatory disease? (Lupus, Crohn's, Ulcerative Colitis, Sarcoidosis, Polyarteritis Nodosa, Eosinophilic Granulomatosis, Granulomatosis with polyangiitis, Rheumatoid arthritis, Kawasaki disease, Celiac disease) _____

Have you had your Plasma Homocysteine levels tested? _____

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

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? Tick the left box for symptoms and conditions you have experienced and the right for symptoms and conditions you suffer from now. Leave <u>BLANK</u> any that is <u>NOT</u> 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	☐	☐	hemorrhoids	☐	☐
	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	☐	☐	kidney/bladder stones	☐	☐
	frequent urination	☐	☐	incontinence	☐	☐	painful urination	☐	☐
	prostate trouble	☐	☐	pus in urine	☐	☐			
WOMEN ONLY	cramps/backache	☐	☐	excessive flow	☐	☐	hot flushes	☐	☐
	irregular cycle	☐	☐	lumps in breast	☐	☐	menopause	☐	☐
	menstrual pain	☐	☐	thrush	☐	☐	pre-menstrual tension	☐	☐
SKIN	acne	☐	☐	eczema	☐	☐	dermatitis	☐	☐
	psoriasis	☐	☐	hives	☐	☐	allergic rashes	☐	☐
	cold sores	☐	☐	mouth ulcers	☐	☐	other	☐	☐
ALLERGIES	hives	☐	☐	sinusitis	☐	☐	iritis	☐	☐
	asthma	☐	☐	hayfever	☐	☐	foods	☐	☐
	skin	☐	☐	itchiness	☐	☐	other	☐	☐
	athletes foot	☐	☐	allergies to animals, dust, pollens, flowers etc.				☐	☐

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	☐

Please Initial that all information is correct, and that nothing was omitted ……