CQ CHIROPRACTIC

Date _____

Confidential New Patient Information

Please fill in the following details, it will give us valuable information we need and will save you time later.

First Name:_____ **Surname:** _____

Mr/Mrs/Ms/Miss/Dr **(Please circle)**

Home Ph _____

If under 18 years of age parent/guardian name:

Work Ph _____

_____ **Mobile** _____

Address: _____

_____ **Email** _____

Date of Birth _____ / _____ / _____

Emergency Contact Info

Occupation: _____ **Name:** _____

Employer: _____ **Contact Number:** _____

Doctor: _____ **Relationship:** _____

How did you find out about us? _____

Medications: (if there is not enough room, please turn this page over).

Name: _____ **Name:** _____

Reason:_____ **Reason:** _____

Previous Surgeries/Operations (Please list) Year: _____ **Procedure:** _____

_____

_____

Car Accidents/Accidents/Trauma History/Fracture/Any Broken Bone:_____

_____

Injuries/Illness/Serious Illnesses: _____

_____

Allergies:_____

Have you or your family ever had any of the following? (Please Tick)

	Self	Family		Self	Family		Self	Family
Cancer			Blood Pressure			Breathlessness		
Stroke			Asthma			IBS		
Athritis			Epliepsy			Indigestion		
Diabetes			Heart Condition			Reflux		

Social Habits (Please Circle)

Do you smoke? **No** **Yes** **Do you drink alcohol?** **No** **Yes**

Do you play sport or exercise **No** **Yes >> If Yes, please list** _____

Your health is our concern,
Your appointment is your responsibility,

If you are unable to keep your appointment or wish to change the time, please advise the office as early as possible. Failure to notify may result in a $20 missed appointment fee. We will send you a text message as a reminder, if you would like to opt out of this service please let us know.

CQ CHIROPRACTIC

Name _____ Date _____

Previous Chiropractor: _____

Last visit to GP/Doctor or work medical: Date: ____/____/____ Reason: _____

PLEASE CIRCLE:

Blurred Vision Y/N	Unsteadiness/Tripping on feet Y/N	Shortness of breath Y/N
Double Vision Y/N	Trouble Swallowing Y/N	Cough Y/N
Loss of Vision Y/N	Numbness on face Y/N	Asthma Y/N
Nausea Y/N	Sensitivity to light Y/N	Other lung problem Y/N
Vomiting Y/N		
Dizziness Y/N	Diagnosed osteoporosis Y/N	Chest Pain Y/N
	Diagnosed Arthritis Y/N	Other heart problem Y/N
Recent change in weight Y/N	Bleeding/Blood clots Y/N	High blood pressure Y/N
Change to bowel/bladder habit Y/N		Leg pain with walking Y/N
Night pain Y/N	Kidney/Bladder infection Y/N	
Fever Y/N	Blood in Urine or Stool Y/N	Depression/Anxiety Y/N
Fatigue Y/N		

Is this complaint due to a Motor Vehicle Injury or Work injury Y/N

Where is your pain? HEAD ☐ NECK ☐ UPPER BACK ☐ LOWER BACK ☐ BUTTOCK ☐ GROIN ☐ HIP ☐ JAW ☐ ARM ☐ LEG ☐ SHOULDER ☐

Is it? LEFT ☐ RIGHT ☐ MIDDLE ☐ BOTH SIDES ☐

Does it radiate to anywhere else? Yes No

If so where? _____

The pain is: SHARP ☐ ACHING ☐ BURNING ☐ TINGLING ☐ MILD ☐ NUMBNESS ☐ UNBEARABLE ☐ SICKENING ☐ JUST ANNOYING ☐ DULL ☐ TIGHTNESS/STIFFNESS ☐ SHOOTING ☐

Severity right now: 1 2 3 4 5 6 7 8 9 10 (10/10 is the worst pain imaginable – please circle)

When did it start? _____

What do you think caused it? _____

Does anything aggravate it? Yes No

Does anything relieve it? Yes No

What have you tried to relieve it? _____

Is the pain worsening? Yes No

Is the pain constant? Yes No

Have you seen other doctors/practitioners for this problem? Yes No

If yes, who? _____

Have you had this problem before? Yes No If yes, when? _____

Was it? (please circle)>> Same Worse not as bad as this episode

Do you have any X-Rays, scans or MRIs of this area? Yes No

If you would like to give us any further information, please write on the back of this form.