

Family Health Professionals Helensvale Southport Chiropractic Clinic



New Patient History

File # _____

The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

Title: **Dr / Mr / Mrs / Miss / Ms**

GIVEN NAMES: _____ SURNAME: _____

OCCUPATION: _____ Date of birth: ____/____/____

ADDRESS: _____

SUBURB: _____ POST CODE: _____

PHONE: (H) _____ (W) _____ (M) _____

Email: _____

Spouse: _____ Children: _____

Emergency Contact Name: _____ Relationship to You: _____ Number: _____

Medical Doctors Name: _____ Contact Number: _____

How did you hear about us? Yellow Pages _____ Google _____ Signage _____ Staff _____

Clinic Patient (please provide their name so we can thank them) _____ Other _____

Reason for this visit: _____

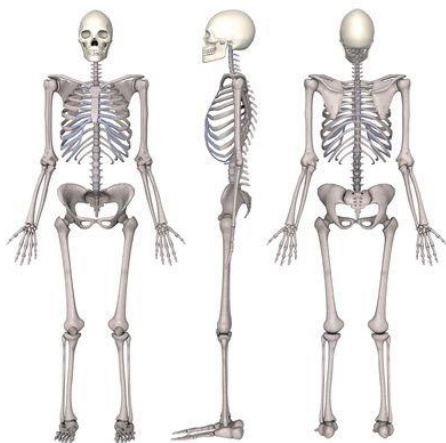
I am only interested in alleviating my pain Yes ___ No ___

I am interested in resolving the cause of my problem Yes ___ No ___

Have you received treatment for this in the past? Yes ___ No ___

Details of past treatment: _____

****PLEASE INDICATE BY CIRCLING AREAS OF CONCERN OR COMPLAINT ON THE DIAGRAM BELOW****



Are you on any medication? (if yes please note below)	Y N
Have you had a motor vehicle accident or serious injury?	Y N
Have you been admitted to hospital in the past 12 months?	Y N
Do you have any xrays, CT scans, MRI, Ultrasound?	Y N
Do you have any ongoing health problems?	Y N
Have you had any unexplained weight loss?	Y N
Have you had any abnormal bleeding from any body part?	Y N
Have you had any recent changes in a mole or freckle?	Y N
Do you have any unusual lumps or swellings?	Y N

If you answered yes to any of the above please supply details here: _____

Is this a Work Cover* or Motor Vehicle** accident claim? Y / N If Yes, When was the date of the accident?
_____ What is your our approved claim number: _____

SYSTEMS REVIEW HISTORY

Please circle either Yes or No to the following questions about your general health. This information will give us a better understanding about your body's overall function.

Headaches	Y N	Neck pain	Y N
Dizziness	Y N	Neck stiffness	Y N
Blurred vision	Y N	Mid back pain	Y N
Ring / buzz in ears	Y N	Chest pain	Y N
Difficulty swallowing	Y N	Palpitations	Y N
Loss of consciousness	Y N	High blood pressure	Y N
Numbness in any body part	Y N	Low blood pressure	Y N
Weakness in any body part	Y N	Heart trouble	Y N
Stroke	Y N	Difficulty breathing	Y N
Depression	Y N	Low back pain	Y N
Nervousness	Y N	Stomach trouble	Y N
Sleeping problems	Y N	Indigestion	Y N
Energy loss	Y N	Liver problems	Y N
Morning tiredness	Y N	Colon problems	Y N
Fainting feeling	Y N	Diabetes	Y N
Sinus problems	Y N	Kidney / bladder problems	Y N
Allergies	Y N	Poor circulation	Y N
Female problems	Y N	Upper limb problems	Y N
Male problems	Y N	Lower limb problems	Y N

Other: _____

Relevant Family History: _____

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

We would like to include you on our email list so you receive our health updates and special offers, please check this box if you DO NOT wish to receive these emails.

I believe the information above is correct to the best of my knowledge. (Please sign below)

Cancellations: We ask that you respect our cancellation policy to ensure we have enough time to contact other clients on our waiting list. 24 hours notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee may be charged.

Patient Name: _____ Signature: _____ Date: ____ / ____ / 20____

** Work cover claims will need to be assessed for eligibility thru work cover online, until that time the patient is responsible for full payment of all treatment. ** For all other 3rd party claims we will provide you with an itemised receipt once you have paid in full, we will not process claims on your behalf.*