



## New Acquaintance Form Adult

First Name: \_\_\_\_\_ Surname \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Email (required for statements): \_\_\_\_\_

Phone (home): \_\_\_\_\_ (mobile): \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

When did you last see a Chiropractor? \_\_\_\_\_ Where: \_\_\_\_\_

Date of last Chiropractic x-rays \_\_\_\_\_

Do you have any children, if so how many? \_\_\_\_\_

Names & Ages (children): \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Partner's name: \_\_\_\_\_

List any medications/ drugs you are currently taking, the reason and the dosage:

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**FEMALE ONLY (FOR X-RAY PURPOSES):** Is there any chance of you being pregnant? YES / NO

### Main areas of concern

I don't have a particular concern – I am here to make sure I don't get any!

#### Primary Problem

Please describe: \_\_\_\_\_

How old were you when the problem started? \_\_\_\_\_

What caused it? \_\_\_\_\_

On a scale of "0" being nothing and "10" being severe, how would you rate the problem?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is the problem constant/ occasional/ weekly/ monthly/ other? \_\_\_\_\_

Do you get referred pain? Yes / No If Yes, where? \_\_\_\_\_

What previous treatment have you had? \_\_\_\_\_

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

### Secondary Problem (if any)

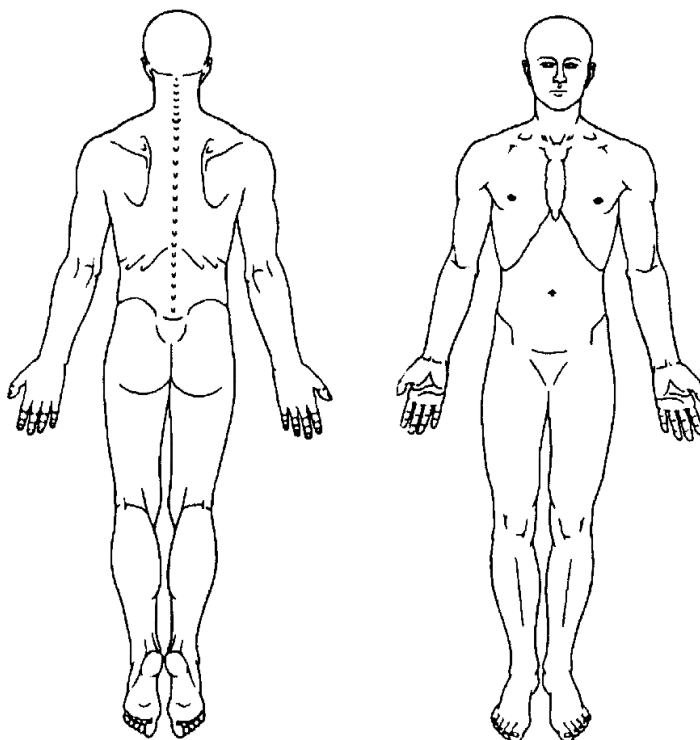
Please describe: \_\_\_\_\_

How old were you when the problem started? \_\_\_\_\_

On a scale of "0" being nothing and "10" being severe, how would you rate the problem?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is the problem constant/ occasional/ weekly/ monthly/ other? \_\_\_\_\_



Please indicate the location of any symptoms.

### Traumas

Please list any incidents that may have had an impact on your spine, from childhood through to today. (Eg. Childhood falls, pregnancy, heavy work, car accidents, sports, etc...)

| Trauma | Age | Severity (at the time)<br>0-10 |
|--------|-----|--------------------------------|
|        |     |                                |
|        |     |                                |
|        |     |                                |
|        |     |                                |

## Safety

It is important in Chiropractic care to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. Have you recently experienced any of the following?

- |  |          |
|--|----------|
| Unsteadiness on your feet or Severe Dizziness    | YES / NO |
| Difficulty talking or swallowing                 | YES / NO |
| Unrelenting Nausea or Vomiting                   | YES / NO |
| Severe Headaches or Neck Pain unlike ever before | YES / NO |
| Ringling in the ears or Recent Visual Changes    | YES / NO |

Likewise, we are concerned that occasionally patients may have a deteriorating or damaged disc in their lower spine. Have you recently experienced any of the following?

- |  |          |
|--|----------|
| Loss of bowel or bladder control   | YES / NO |
| Loss of leg muscle size or numbness in the legs                          | YES / NO |
| Difficulty standing or progressive weakness in the legs                  | YES / NO |
| Shooting or sharp pain in the low back or legs when coughing or sneezing | YES / NO |

## General Health History

Any history of bone thinning disease such as osteoporosis, or long term corticosteroids? YES / NO

Do you have ANY health problems (e.g. Diabetes, asthma, cancer, high blood pressure, etc...)? YES / NO

Any recent large loss of weight? YES / NO

Have you any implants, surgical clips, or foreign bodies such as pace-makers? YES / NO

Do you give permission for us to share your case information with your immediate family? YES / NO

Please note that we do not accept any third party causes such as Work Cover or Motor Vehicle Accident Claims.

I \_\_\_\_\_, have answered this form truthfully and accurately and understand and give my consent for any of the Chiropractors at Abundant Life Chiropractic to perform the necessary consultation and exam which may include but not limited to: Postural photos, Heart Rate Variability, Rolling Thermal Scan, Chiropractic physical exam and Spinal X-rays.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

(Parent or Guardian to also sign if patient is under 18)