

NEW PATIENT FORM

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 _____

Relationship Status: _____ Partner: _____ Children: _____

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

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

☐ 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? _____

Is the problem constant/ occasional/ weekly/ monthly/ other? _____

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

What previous treatment have you had and when? _____

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...)

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. I also agree to pay in full the fees for this to be performed at the time of the visit.

Patient Name _____

Signature _____ Date: _____

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