



CHIROPRACTIC
"THE KEYS TO OPTIMAL HEALTH & WELLBEING"

Contact Information

- I. **Title** (Please circle one): Dr Mr Mrs Ms Miss Master
- Surname:** _____ **First Name:** _____
- Middle Name:** _____ **Preferred Name (optional):** _____
- Address:** _____
- Suburb:** _____ **State:** _____ **Postcode:** _____
- II. **Birth Date:** _____
- Telephone:** Preferred Contact # _____ Home/Mobile Work
Other Contact # _____ Home/Mobile Work
- Email:** _____

- III. **Would you like to receive our newsletter via email?** No Yes
- IV. **Do you have a Health fund?** No Yes (Please specify): _____
- Are you a:** Student Pensioner Veteran **ID #:** _____
- Marital Status:** Single Married Divorced Other
- Number of Children:** _____
- V. **Who is your Medical Advisor?** None (Name) _____
- Clinic Name/Address: _____
- VI. **Would you like us to remind you of appointments?** No Call SMS Email
- VII. **What is your Occupation?** _____
- Is this a Work Cover or CTP Claim?** No Yes (If so, please inform our front desk staff)

- VIII. **How did you hear about this clinic (Please provide as much detail as possible)?**
- Advertising: _____ Healthcare Referral: _____
- AFL Sponsorship: Sandgate or Zillmere? Family Referral: _____
- Yellow Pages: Telephone Book or Online? Other Referral: _____
- Website: New Era Online or UPC Spine? Online Search _____
- Promotional Event: _____ Other (Please specify): _____
- IX. **Have you seen a chiropractor before?** No Yes (How long ago?) _____
- If so** Name of the chiropractor(s) _____
- And** Did it help you? No Yes
- X. **Emergency Contact**
- Name:** _____ **Relationship:** _____
- Contact #:** _____

Please Read Before Continuing

I understand and agree that New Era Chiropractic has the right to refuse to accept me as a patient before treatment begins. The taking of a history and conducting a physical examination are not considered treatment, but are part of the information gathering process required to determine if chiropractic care may help me. I have read this statement and give my consent for the information gathering process.

Signature: _____ **Date:** _____



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Primary Condition & Symptoms ... How can we Help You?

01. What is your major current problem or condition?

If you have more than one major problem, please request an additional sheet from our front desk staff.

Draw where you feel the problem

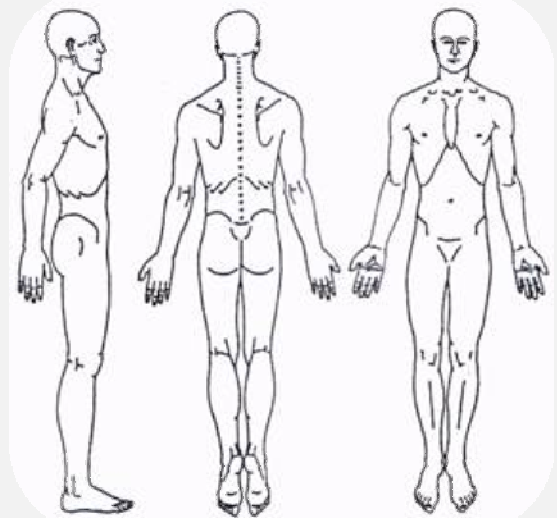
02. What happened to cause the problem?

03. Have you had this or a similar problem before?

No Yes (Please describe)

04. How long have you had this problem? _____

And Is it... Getting Better Staying the Same
 Getting Worse Comes & Goes



05. What makes your condition better? _____

What makes your condition worse? _____

06. Please describe your symptoms? _____

For example: achy, sharp, annoying, tingling, etc

07. Does the problem radiate anywhere? No Yes (Describe) _____

08. Rate the severity of your problem: Ideal 0 ----|----|----|----|----|----|----|----|----|----10 Agony

09. When is the problem worst? Morning At night in bed On-and-off
 (tick all that apply) Afternoon Only doing activity Constant
 Evening Other _____

10. Have you received medical attention or any other treatment? _____

For example: GP, physio, ice/heat, pain-killers, etc

If so What affect did it have? _____

11. Has the problem disrupted any of your usual daily activities? _____

For example: work, exercise, sleep, doing laundry, etc.

12. Do you have other spinal problems or health concerns at this time? No Yes (Please list) _____

Lifestyle Health & Habits

19. Does your work involve lots of ...

- | | | |
|---|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting (___ Kg) | <input type="checkbox"/> Driving (___ Hours) |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Loud Machinery/Noise | <input type="checkbox"/> High Stress/Deadlines |
| <input type="checkbox"/> Bending/Twisting | <input type="checkbox"/> Arms Raised Above Head | <input type="checkbox"/> Other _____ |

20. Are you satisfied with your job? No Yes

21. Please indicate any stressful or personal lifestyle changes in the past 2 years:

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Physical/Emotional Abuse | <input type="checkbox"/> Death of Family/Friend |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Birth of Child | <input type="checkbox"/> Caregiver to Relative | <input type="checkbox"/> Disabled Relative at Home |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Job Change/Loss | <input type="checkbox"/> Change of Financial Status | <input type="checkbox"/> _____ |

22. Please indicate your dietary habits:

- | | | | | | |
|---------|-------------------------------|---|-------------------------------|-----------------------------|------------------------------|
| Alcohol | <input type="checkbox"/> No | <input type="checkbox"/> Drinks/Week? _____ | Family History of Alcoholism? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Coffee | <input type="checkbox"/> No | <input type="checkbox"/> Cups/Day? _____ | Decaf? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tea | <input type="checkbox"/> No | <input type="checkbox"/> Cups/Day? _____ | Green or Herbal? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Water | <input type="checkbox"/> No | <input type="checkbox"/> Glasses/Day? _____ | Cordial or Soft Drink? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diet | <input type="checkbox"/> Poor | <input type="checkbox"/> Could be Better | Fast-Food/Take-away per Week? | _____ | |
| | <input type="checkbox"/> Good | <input type="checkbox"/> Vegetarian | 5+ Fruit/Veggies per Day? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

23. Please indicate any other personal lifestyle habits:

- | | | | | |
|----------|---|--|---------------------------------------|-------|
| Tobacco | <input type="checkbox"/> No | <input type="checkbox"/> Cigarettes | Number per Week | _____ |
| | <input type="checkbox"/> Chew | <input type="checkbox"/> Cigars | How long have you Smoked? | _____ |
| | <input type="checkbox"/> Quit (When?) | _____ | How long before you quit? | _____ |
| Sleep | <input type="checkbox"/> Back | <input type="checkbox"/> Stomach | Average Hours per Night? | _____ |
| | <input type="checkbox"/> Side | <input type="checkbox"/> Toss-and-turn | Age of Mattress (Years)? | _____ |
| Exercise | <input type="checkbox"/> Regular | <input type="checkbox"/> Irregular | _____ Minutes/Day or _____ Hours/Week | |
| | <input type="checkbox"/> I do not do as much exercise as I need | | | |

24. List any activities/sports in which you participate:

And Is your condition affecting any of these activities?

- No Yes (Describe) _____

25. The final question (#25) is continued on the next page.

25.

Review of Systems

Please tick (☑) if you have an ongoing history of any of the following symptoms?

General

- Always Feel Cold
- Always Feel Hot/Feverish
- Anxiety
- Balance Problem/Dizzy
- Depression
- Fainting
- Fatigue
- Frequently Sick
- Insomnia
- Memory Loss
- Pain Waking at Night
- Seizures
- Tremors
- Unexplained Sweats
- Unexplained Weight Loss

Muscle & Joint Pain

- Arthritis
- Bursitis
- Headaches or Migraines
- Leg Cramps
- Low Back Pain
- Neck Pain & Stiffness
- Pain between Shoulders
- Pins & Needles in Arms
- Pins & Needles in Legs
- Sciatica
- Scoliosis
- Swelling in Joints

Skin

- Boils
- Bruise Easily
- Dryness
- Eczema or Allergic Rash
- Itching
- Rash
- Varicose Veins

Other

- _____
- _____

Cardiovascular

- Anaemia
- Hardening of the Arteries
- High Blood Pressure
- Low Blood Pressure
- Chest Pain ("squeezing")
- Poor circulation
- Rapid Heart Beat
- Swelling in Ankles

Respiratory

- Asthma
- Chest Infection
- Chronic Cough
- Difficulty Breathing
- Spitting Blood or Phlegm
- Wheezing

Gastrointestinal

- Appetite Excessive
- Appetite Poor
- Bloating in Abdomen
- Blood in Vomit
- Blood in Stool
- Indigestion
- Irritable Bowel
- Gallbladder Problems
- Haemorrhoids
- Hernia
- Jaundice
- Liver Problems
- Nausea/Vomiting
- Stomach Pain/Reflux

Genitourinary

- Bed Wetting
- Blood in Urine
- Frequent Urination
- Excessive Thirst
- Incontinence
- Kidney Stones
- Painful Urination
- Urinary Tract Infection(s)

Face & Head

- Crossed Eyes
- Deafness
- Ear Infection(s)
- Ear Ringing or Tinnitus
- Enlarged Glands
- Enlarged Thyroid
- Eye Pain
- Facial Drooping
- Facial Pain
- Gum Problems
- Grind Teeth/Clench Jaw
- Hayfever
- Hoarseness in Throat
- Jaw Problems
- Problems with Smell
- Problems with Taste
- Visual Disturbances

Male Only

- Can't start/stop urine flow
- Erectile Dysfunction
- Infertility
- Penile Discharge
- Prostate Trouble
- Testicle Pain

Female Only

- Abdominal Cramps
- Breast Lumps
- Hormone Replacement
- Infertility
- Irregular Menstrual Cycle
- Menstrual Flow Excessive
- Menstrual Flow Scanty
- Menopausal Symptoms
- Miscarriage
- Painful/Inflamed Breasts
- Painful Menses
- Vaginal Discharge
- Possible Pregnancy