# CONFIDENTIAL NEW PATIENT INFORMATION

Welcome to our practice – here, we consider you part of our family, so we invite you to get comfortable and feel at home. You may observe that our clinic is equipped differently and offers a unique ambiance. This is because Dr. Michael brings over a decade of expertise in Chiropractic Biophysics, specializing in addressing pain, enhancing posture, and optimizing body performance. Our goal is to support you through your health journey, understand the challenges you're facing, and assist you in reaching your health goals. While we recognize that filling out forms might not be the most enjoyable task, your thorough responses are invaluable to us in providing you with the best possible care.

Name: _____ Date: _____

Address: _____

Mobile: _____ Email: _____

Occupation: _____ Relationship Status: _____

Number of Children: _____ DOB: _____ /_____/_____

How did you find out about us? _____

How can we help you? _____

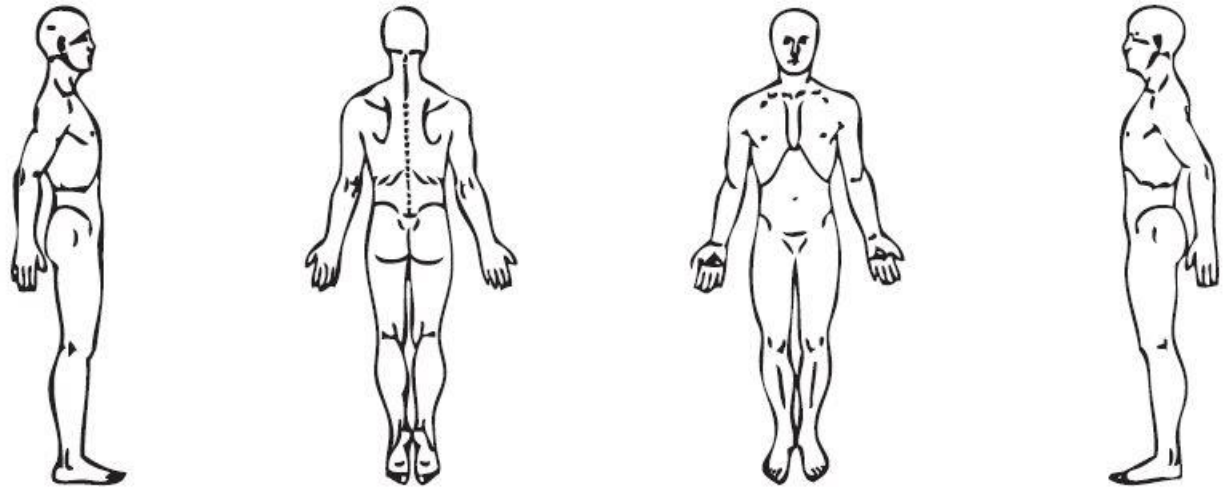
When did this problem begin? _____

What do you think potentially caused this? (Injury, Accident, Work, Repetition)

_____

**PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE: -**

R L R R L L



## Your Presenting Complaint

Describe your pain or problem _____

On a Scale of 1 to 10 how bad is it now? (1- Minor _____ 10 -Very Painful)

Where else does your pain go?_____

What **aggravates** your problem? _____

What **relieves** your problem? _____

What have you tried to help? _____

Who have you seen to help this? _____

How do you feel emotionally about your problem? _____

**Please Circle What Your Pain or Problem Interferes with:**

| | | | | | |
|---|---|---|---|---|---|
| Sleep | Work | Concentration | Energy | Gym | Physical Activity |
| Self Care | Recreation | Home Duties | Patience | Productivity | Relationships |

**Please list trauma, surgeries or medical diagnoses:**

_____

**If you have any of the following please circle:**

Pain Waking @ Night Cancer Stroke Change in Bowel or Bladder Balance Changes

High Blood Pressure Change in Taste or Smell Dizziness/Vertigo Unexplained Weight Loss

Numbness/Tingling Change in Vision Other_____

**HEALTH & WELLBEING – Please rate 0 – 10 in each area**

| | | | |
|---|---|---|---|
| Posture | _____ / 10 | Active Lifestyle | _____ / 10 |
| Strength | _____ / 10 | Nutrition | _____ / 10 |
| Endurance | _____ / 10 | | |
| Sleep | _____ / 10 | Mobility | _____ / 10 |
| Energy | _____ / 10 | Overall Health | _____ / 10 |

**CONSENT TO EXAMINATION**

I acknowledge I have given accurate information, and it is my responsibility to inform this office of any changes in my health. I agree to a consultation, and examination to see if my case is appropriate for chiropractic care to achieve my health goals. I understand the examination may include spinal palpation, range of motion, posture photo, orthopaedic & neurological testing. If clinically indicated, it may be appropriate to undergo spinal X-ray examination.

**FEMALE ONLY :** Are you pregnant or possibly pregnant? Yes / No

Do you consent to X-ray Examination if clinically indicated? Yes / No