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. 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: ________________________

Work Environment(circle): Standing Sitting Computer Physical Labour Lifting Driving

Number of Children: ____________________ DOB: ________ /_________/_________

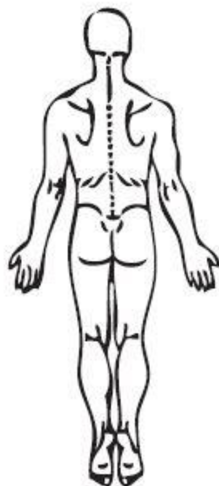
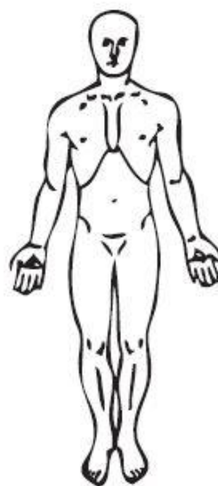
How did you find out about us? ____

What brings you to see us? ____

How & when did it begin? ____

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

R L R R L L

Your Presenting Complaint – Please circle appropriate responses

Describe your pain or problem ____

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

How is your complaint progressing: Better Same Worse

Pain Duration: Constant Mornings End of Day Comes/Goes Other:_________

Does anyone in your family suffer with the same condition?: Yes No

If your pain goes elsewhere, where does it radiate? ____

What makes your condition worse: Bending Sitting Walking Coughing Sneezing
Defecation Stairs Lifting Standing

Prior Interventions/Treatment: Massage Physio Chiro Surgery
Medication Heat Stretch Ice Other_________

How do you sleep? Poorly Waking up a lot Well Side Back Front Lightly Deeply

On an emotional level, how do you feel about your condition? __________________________________

Life Impact – Please Rate out of 10 the impact your condition is having in your life.

Home	No Impact	0	1	2	3	4	5	6	7	8	9	10	Debilitating
Work		0	1	2	3	4	5	6	7	8	9	10	
Concentration		0	1	2	3	4	5	6	7	8	9	10	
Relationships		0	1	2	3	4	5	6	7	8	9	10	
Hobbies		0	1	2	3	4	5	6	7	8	9	10	

Your Spine Health

Postural distortions run in families, and people with similar activities. Have you ever been told you have a spinal curvature, spinal arthritis, or inherited disc problem? Yes No

Spinal Misalignment cause decay & degeneration which results in grinding and cracking. Do you ever hear noises when you move your head or neck? Yes No

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or back? Yes No

A poorly functioning spine and nervous system can affect the way your entire body functions. Does the problem affect your work, or any aspects of your sports or hobbies you enjoy?

____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture out of 10? (0 Terrible __________10 Excellent)

Stress can accelerate or cause spinal damage.

Rate your stress over the last 90 days (0 Low________ 10 High)

Impacts as little as 7km/hr can cause whiplash which can damage spinal joint, ligament and may cause mild traumatic brain injury, have you ever been involved in an auto accident? Yes No

If yes please give details:____

What we do day to day can affect our body over time, please list a brief work history.

____

Please list sporting history & sporting injuries:____

Please list any slips, falls, or other accidents in your life – include sprains, broken bones, concussion.

____

How often do you?:

Smoke Tobacco/Vape –	None	Daily	Weekly	
Exercise –	None	Daily	2-3x/wk	Weekly
Take Pain Relief –	None	Daily	Weekly	Sometimes

Are you happy with the way you look and feel?	Yes	No	
How long has it been since you felt your best?	Days	Months	Years
How long have you been thinking of pursuing your health goals?	Days	Months	Years

GOALS OF CARE: **What are your health goals?**

Less Pain / Symptoms	Reducing Stress	Increasing Vitality & Energy
Return to Normal	Health & Longevity	Increase Quality of Life

What specific benefits do you want by addressing this? ____

Why is it important for you to resolve this? ____

How committed are you to achieving your health goals? 0 not committed_______ 10 very committed

How do you want us to handle your problem? Temporary Relief Full Correction

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.

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

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

Name: ____________________________ Signature: ______________________________ Date: _________