CENTRAL QUEENSLAND CHIROPRACTIC CENTRE

Date _____

Confidential New Patient Information

Please fill in the following details, it will give us valuable information we need and will save you time later.

Name

Mr/Mrs/Ms/Dr_____

If under 18 years of age parent/guardian name

_____

_____

Address _____

Date of Birth ___ / _____ / _____

Occupation _____

Employer _____

Medical Doctor _____

How did you find out about us _____

Phone Numbers

Home _____

Work _____

Mobile _____

Email _____

Incase of Emergency Contact

Name _____

Contact number _____

Relationship _____

Medications

Name _____

Reason_____

*If you have more medications please ask reception for additional paper

Name _____

Reason _____

Previous Surgeries/Operations (Please list) Year _____ Procedure _____

_____

_____

Car Accidents/Accidents/Trauma History _____

_____

Injuries/Illness/Serious Illnesses _____

_____

Allergies _____

_____

_____

Have you or your family ever had any of the following? (Please Tick)

	Self	Family		Self	Family		Self	Family
Cancer			Blood Pressure			Breathlessness		
Stroke			Asthma			IBS		
Athritis			Epliepsy			Indigestion		
Diabetes			Heart Condition			Reflux		

Social Habits (Please Circle)

Do you smoke? No Yes

Do you drink alcohol No Yes

Do you play sport of exercise No Yes If Yes, please list _____

_____

Your health is our concern,

Your appointment is your responsibility,
If you are unable to keep your appointment or wish to change the time, please advise the office as early as possible.
Failure to notify may result in a $20 missed appointment fee.

PATIENT FORM CONTINUED **Date___**

_____

Previous Chiropractor _____

Last visit to GP/Doctor or work medical

Date: _____

Reason: _____

Night pain Y/N

Recent change in weight Y/N

Change to bowel habit Y/N

CHIEF COMPLAINT
Is this complaint due to a Motor Vehicle Injury or Work injury Y/N

Where is your pain? _____
Is it? LEFT RIGHT MIDDLE BOTH SIDES

Does it radiate to anywhere else? Yes No

If so where? _____

Numbness or Tingling? Yes No

Severity 1 2 3 4 5 6 7 8 9 10

When did it start? _____

What do you think cause it? _____

Does anything aggravate it? Yes No

Does anything relieve it? Yes No

What have you tried to relieve it? _____

Is the pain worsening? Yes No

Is the pain constant? Yes No

Have you seen other doctors/practitioners for this problem? Yes No

If yes, who? _____

Do you have any Xrays, scans or MRIs of this area? Yes No

NOTES

_____

CHIROPRACTIC USE ONLY

DIZZINESS: Y/N
NAUSEA: Y/N
DIPLOPIA: Y/N
DYSTAXIA: Y/N
NYSTAGMUS: Y/N