DR. NICK CHIROPRACTIC

New Acquaintance Form
Adult

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_____

Do you have any children, if so how many? _____

Names & Ages (children): _____

Relationship Status: _____Partner's name: _____

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:

_____

_____

Main areas of concern

❑ **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?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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

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

What previous treatment have you had? _____

What makes the problem better? _____

What makes the problem worse? _____

Secondary Problem (if any)

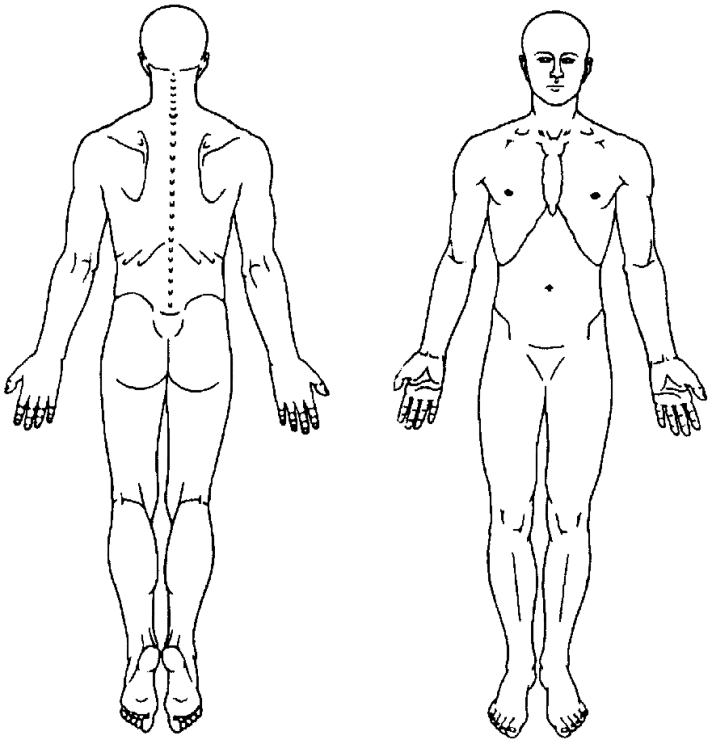
Please describe: _____

How old were you when the problem started? _____

On a scale of "0" being nothing and "10" being severe, how would you rate the problem?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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



Please indicate the location of any symptoms.

Traumas

Please list any incidents that may have had an impact on your spine, from childhood through to today. (E.g. Childhood falls, pregnancy, heavy work, car accidents, sports, etc.…)

Trauma	Age	Severity (at the time) 0-10

Safety

It is important in Chiropractic care to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. Have you recently experienced any of the following?

Unsteadiness on your feet or Severe Dizziness	YES / NO
Difficulty talking or swallowing	YES / NO
Unrelenting Nausea or Vomiting	YES / NO
Severe Headaches or Neck Pain unlike ever before	YES / NO
Ringing in the ears or Recent Visual Changes	YES / NO

Likewise, we are concerned that occasionally patients may have a deteriorating or damaged disc in their lower spine. Have you recently experienced any of the following?

Loss of bowel or bladder control	YES / NO
Loss of leg muscle size or numbness in the legs	YES / NO
Difficulty standing or progressive weakness in the legs	YES / NO
Shooting or sharp pain in the low back or legs when coughing or sneezing	YES / NO

General Health History

Any history of bone thinning disease such as osteoporosis, or long term corticosteroids?	YES / NO
Do you have ANY health problems (e.g. Diabetes, asthma, cancer, high blood pressure, etc…)?	YES / NO
Any recent large loss of weight?	YES / NO
Have you any implants, surgical clips, or foreign bodies such as pace-makers?	YES / NO
Do you give permission for us to share your case information with your immediate family?	YES / NO

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 these to be performed at the time of the visit.

Patient Name _____

Signature _____ Date: _____

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