New Patient Information
Back To Health Family Chiropractic

Name_____ Date of Birth_____

Address_____

Suburb_____ Post code_____

Home Ph_____ Mobile_____ Occupation _____

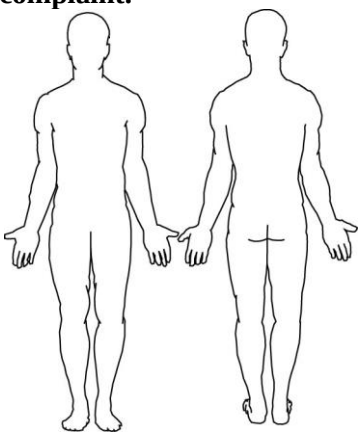
E-mail_____ How did you hear about us? _____

Have you had chiropractic care before? Y/N If So When? _____ Are you in a Health Fund? Y/N

Do you suffer from any of the following complaints? Please tick

❑ Neck Pain	❑ Middle Back Pain	❑ Low Back Pain	**Women Only**
❑ Headaches/Migraines	❑ Asthma	❑ Leg Pain	❑ Period Problems
❑ Sleeping difficulties	❑ Heart Condition	❑ Pins and Needles in legs	❑ Number of Children _____
❑ Dizziness	❑ Blood Pressure	❑ Groin Pain	❑ Normal Delivery _____
❑ Sinus Problems	❑ Gall Bladder Problems	❑ Knee Pain	❑ Any miscarriages _____
❑ Shoulder Pain	❑ Liver Condition	❑ Constipation	
❑ Arm Pain	❑ Stomach Problems	❑ Diarrhea	
❑ Pin and Needles in arms	❑ Diabetes	❑ Cramps	
❑ Thyroid Condition	❑ Sudden Loss Of Weight		

On the diagram please circle the areas of complaint.



Please rate your pain level

(_____)

1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

How long have you had this complaint for?_____

Do you know the cause of your main complaint? _____

How is your condition progressing? -Getting worse -Staying the same -Getting better -Comes and goes

What aggrevates your complaint? -Sitting -Standing -Walking -Driving -Sports Other_____

What relieves your complaint? -Heat - Ice -Stretching -Rest -Massage -Pain killers -Nothing
Other_____

Please turn over and continue

History of traumas:
Most of us suffer from minor/major traumas through our life. Please list all injuries(even if only small) from childhood till now.

Please list all car accidents/falls/slips/sports injuries/work injuries you have had including year:

_____

_____

_____

Please list all surgeries you have had and when:

_____

_____

What Medication's/Vitamin's are you currently taking?

_____

_____

Do you smoke? Y/N Do you drink? Y/N

Please tick the type of care you prefer.

- ❑ Relief Care (removes symptoms only)
- ❑ Corrective Care (have the problem corrected)
- ❑ Wellness Care (optimal health and wellbeing)

Informed Consent To Chiropractic Care

Chiropractic is recognized as being an effective and safe method of care for many conditions. However, you must recognize that there are risks associated with all health care procedures which you should be informed about.

Chiropractic care of the Neck may damage blood vessels and give a rise to stroke or stroke-like symptoms (less than 1 in 2,150,000). If any adjustments are required you will be tested beforehand to ensure safety. Other very slight risks include strain/injury to the ligament or disk in the neck (less than 1 in 139,000) or low back (1 in 62,000)

If you have any questions related to the chiropractic care you are about to receive or about alternative options, please speak to the chiropractor.

I understand the above information and give my consent to chiropractic care.

Patient Name:_____ Patient Signature:_____

Chiropractors Name: Mohamad Zoud Chiropractors Signature:_____

Date:_____