LATROBE CHIROPRACTIC

New Patient Registration

Demographic Information

Title ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐Other ....
Given names:
Surname:
Date of Birth / / Sex: ☐ Male ☐ Female
Street Address:
Suburb: Postcode:
Home Phone:
Mobile Phone:
Work Phone:
Email:
Do you have a health care card? Yes/No
Do you have a veteran's affair card? Yes/No
Marital Status:
Occupation:
Are you a full-time student?
Emergency Contact Person:
Phone number:
Relationship:
Have you Had Chiropractic care before? Yes/No
Previous Chiropractor:
Date of last chiropractic visit:
Is this a work safe or TAC case? Yes/No
How did you hear about our practice? Name of person who referred you to us__________________

Your health profile

As a full spectrum chiropractic clinic, we focus on your ability to be healthy. Your body regularly faces physical, emotional and chemical stresses, which may impact on your overall health. Our initial goal at Latrobe Chiropractic is to address the issues that brought you here, in order to improve your functioning and overall health. Future goals may include efforts to optimise your health and prevent recurrences, through wellness care.

Below are several questions that may seem unrelated to the purpose of your appointment. However, please answer these questions carefully as they can affect your overall course of chiropractic care.

What is the purpose of your visit today?

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How long have you had this condition? _________________

Is there anything that relieves this condition?

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Is there anything that worsens this condition?

____

Have you had any treatment for this condition?

____

On a scale of 1-10 (1=very poor, 10=excellent) please describe the state of your:

Eating habits _____________ Pillow _________

Sleeping position____________ Mattress _____________

Exercise Habits:

Type of exercise______________________________________

Frequency ____

How many hours per day do you spend at a desk? __________

____

On a scale of 1-10 (1=none, 10=extreme) please describe your psychological/emotional stress levels:

Occupational ____________ Personal ________________

Please tick the appropriate box and give details where required.

Do/did you smoke? ❒ Yes ❒ No __________________

Do/did you drink alcohol? ❒ Yes ❒ No __________________

Do you wear orthotics or heel lifts? ❒ Yes ❒ No ___________

Do you have a regular Allied health consultation (inc. Massage, Acupuncture, Naturopathy, Physiotherapy, Kinesiology, etc)?

Yes/No If Yes, which: ______________________________

Therapist name: __________________________________

How Often? _____________________________________

General history

Is the condition of your health interfering with your:

❒ Work ❒ Exercise/Sport ❒Walking ❒ Leisure/Hobbies ❒ Sleep ❒ Positive Mental Attitude

❒ Other ____

Please list any accidents, injuries or falls, including motor-vehicle accidents, work-related accidents, sports injuries or otherwise:

Type ____ Date ____________________

Type ____ Date ____________________

Type ____ Date ____________________

Please list any surgery you have had and when:

Type ____ Date ____________________

Type ____ Date ____________________

Type ____ Date ____________________

Please list any medications (prescription and non-prescription), vitamins or supplements you are taking and why: ______________

____

____

Have you ever had X-Rays, MRI or CT taken? __________ **If yes, what area of your body, and when?**

____

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Please indicate if you have/have had any of the following conditions:

❒ Heart Disease	❒ Diabetes	❒ Aneurysm	❒ High blood pressure/cholesterol
❒ Stroke	❒ Cancer	❒ HIV/AIDS	❒ Epilepsy
❒ Osteoporosis	❒ Arthritis	❒ Asthma	❒ Other – please specify below

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Please indicate if you have/have had any of the following symptoms in the last 12 months:

❒ Back or neck pain/stiffness	❒ Headache	❒ Fatigue	❒ Sleeping problems
❒ Indigestion	❒ Nausea/Vomiting	❒ Anxiety	❒ Depression
❒ Bowel or bladder problems	❒ Blurred vision	❒ Difficulty breathing	❒ Chest pain
❒ Menstrual pain/irregularity	❒ Allergies	❒ Fever	❒ Ringing in ears
❒ Dizziness/Loss of balance	❒ Numbness/Pins and needles	❒ Convulsions/Seizures	❒ Cold hands or feet

Thank you for taking the time to complete this form!