

## NEW PATIENT FORM



<b>THIS PAGE TO BE COMPLETED BY PATIENT</b>	Date :
<b>PERSONAL DETAILS – Please write clearly</b>	Case No:
	D.C.:

Surname :	Forenames:
Date of Birth:	Marital Status:

Address :  
.....  
e-mail

Children (age & gender):

Contact phone numbers:	Home:	Work:	Mobile:
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Occupation:	No of years in this job ?:	Employer:
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Briefly describe your main occupational physical activity :

Do you have medical insurance ? YES / NO	Which Company ?
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How did you hear about Burnham Family Chiropractic Centre ? (please tick)

<i>Yellow Pages</i>	<i>British Chiropractic Assoc.</i>	<i>Your G.P.</i>	<i>Passing By/ Knew of clinic</i>
<i>Advertisement ( where ?)</i>	<i>Recommendation (whom ?)</i>		

### MEDICAL AND GENERAL HEALTH INFORMATION

Name of your G.P.:	Surgery:
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Address:	Tel : (if known):
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Medication currently being taken (frequency & dose):  
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Any broken bones (year):  
.....

Any X-rays or MRI scans (where, when and area of body)

Any road traffic accidents or other major trauma (year)  
.....

Any past operations:  
.....

Have you received any other medical treatment recently ? NO / YES : (details):  
.....

Do you smoke ? NO / YES ..... per day for ..... years.	Do you drink alcohol ? NO / YES ..... units/week
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Do you exercise or play sport regularly ? (if so what do you do):  
.....  
Frequency per week ?:

What is your usual sleeping position ?:

### FEMALE PATIENTS ONLY

Are you pregnant ? YES / NO / NOT SURE	End of last menstrual cycle (approx. date):
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Method of contraception :	Last cervical smear:
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Do you undertake a regular breast examination? (self or other health care professional): YES / NO

Excluding your main complaint, have you or any family member suffered from:  
**(tick as appropriate)**

	Yoursel (details)	Your family (details)
Migraine/headaches		
Dizziness/Tinnitus		
Facial pain		
Jaw clicking/locking		
Ear/nose/throat problems		
Neck or arm pain		
Back or leg pain		
Heart or stroke problems		
Breathing difficulty		
Allergy or asthma		
Digestive problems		
Bladder or bowel disorders		
Abdominal bloating/pain		
Epilepsy/nervous disorder		
Depression		
Multiple sclerosis		
Arthritis		
High blood pressure		
Other circulation problem		
Cancer		
Liver or kidney problem		
Diabetes		
Reproductive problems		
Severe period pain		
Dietary restrictions		
Other (please state)		

### Your Primary Complaint

**Briefly describe your main reason for consulting a chiropractor:**

Please indicate the pain level of your current primary complaint. (X at worst, 0 at best)

No pain 

0	1	2	3	4	5	6	7	8	9	10
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 Maximum pain

### Consent to examination

I understand that my chiropractic assessment will necessitate an appropriate physical examination, to which I consent.

Signed .....

Dated.....