NEW PATIENT INTAKE FORM

Title: _____ Forename(s): _____ (Preferred name): _____ Surname: _____

Address: _____

Postcode: _____ Contact number: _____

Email: _____ Date of birth: _____ Age: _____

Marital status: _____ Spouse's Name: _____

Do you have children? ☐ Y ☐ N If yes, how many? _____ What age(s)?

_____ Occupation: _____ Name of

Employer: _____ What is your reason for visiting us?

_____ Whom may we thank for referring

you to see us? _____ If you have pain/symptoms, please

answer the following:

Does the complaint radiate to any other areas of the body? ☐ Y ☐ N If yes, where to? _____

Describe when and how this began: _____

_____

How frequent is the complaint present? ☐ Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Other: _____

Any past episodes? ☐ Y ☐ N If yes, when was the first episode? _____

Have you previously seen a: ☐ Chiropractor ☐ Physiotherapist ☐ Osteopath ☐ GP Did this help? ☐ Y ☐ N

Please answer the following, even if you feel it is unrelated, as it is important we get a full picture of your health:

Any previous trauma? ☐ Car accident ☐ Fall ☐ Sport injury ☐ Broken bones ☐ Pregnancy ☐ Other:

_____ How long do you sit on a daily basis? ☐ All day ☐ Most of the day ☐ Part of the day ☐ Hardly,

active most of the day How often do you exercise on a weekly basis? ☐ Daily ☐ Most days ☐ Some days ☐ Never

Do you feel that your posture is poor? ☐ Y ☐ N

Rate the following on a scale of 1 to 10 (10 being the highest): Energy _____ Stress ____ Health _____ Happiness ____

* 1 unit = 1/3 of a pint of beer, ½ a glass of wine or 25ml of a spirit

Do you smoke? ☐ Y ☐ N How many a day? _____ Do you drink alcohol? ☐ Y ☐ N How many units per week?

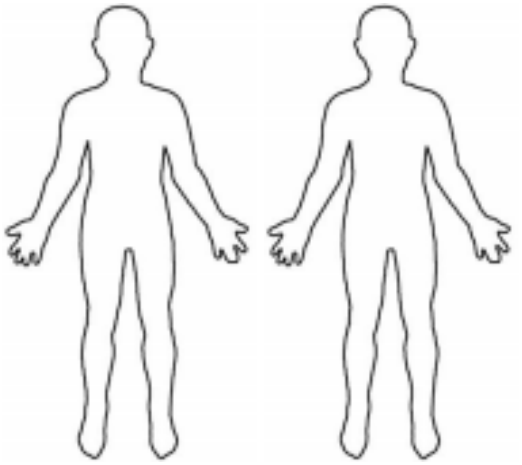
Before we create a customised care plan for you, it would be helpful to know:

How long do you think it will take to resolve your complaint? _____

What do you hope to do better or enjoy more as a result of Chiropractic care? _____

Please indicate on the diagram below where you feel any discomfort:

Front Back



Describe how this feels e.g. sharp, burning, shooting etc:_____

Please tick if you have suffered from any of the below issues, either currently or in the past:

Acid reflux/heartburn	Allergies	Arm and/or hand pain	Arthritis
Asthma	Cancer	Constipation	Depression/Anxiety
Diabetes	Dizziness	Fatigue	Fertility problems
Headaches/migraines	Heart trouble	High blood pressure	Indigestion
Leg and/or foot pain	Low back pain	Menstrual problems	Mid back pain
Muscle spasm	Neck Pain	Numbness	Pins and needles
Poor circulation	Scoliosis	Sinus problems	Sleeping problems
Slipped disc(s)	Stomach problems	Thyroid problems	Whiplash

List any medications you are currently taking: _____

List any family health problems: _____

Note here any other relevant information: _____

The above information provided is correct to the best of my knowledge and I consent to a chiropractic examination.

SIGNED: **DATE:**

X-rays will be taken if deemed clinically necessary. Under law, X-rays taken will remain the property of the clinic. X rays will be available on a CD for a cost of £15. I agree to these terms and consent to X-rays being taken.

SIGNED: **DATE:**

(All of the above is signed by a parent/legal guardian if the patient is under 16 years of age).

FEMALES ONLY (in accordance with policy for safe use of X-ray)

When was the start of your last period:

_____ Is there any possibility that you are

pregnant: ☐ **Y** ☐ **N Are you using reliable contraception:** ☐ **Y** ☐ **N**