Baysie CHIRO

NEW PATIENT INTAKE FORM

Please try to fill in as much information as possible - this will help us give you the best possible care.

BAYSWATER 2 GRAND PROMENADE 9271 6214

PERSONAL INFORMATION *(Please fill **both** sides completely)*

TITLE (PLEASE CIRCLE): Mr/ Mrs/ Ms/ Miss/ Mst/ Dr

TODAYS DATE: ____ /____ / ____

FIRST NAME: _____SURNAME_____ DATE OF BIRTH: _____

ADDRESS: _____ SUBURB: _____

CONTACT NUMBER: _____ EMAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____ YEARS AT PRESENT WORK____

EMERGENCY CONTACT: _____ NUMBER: _____

HEALTH COVER: None ☐ Workers comp ☐ Motor Vehicle Accident ☐ DVA ☐
Enhanced Primary Care (EPC) ☐ Private health ☐ _____

WHO RECOMMENDED US? : ☐ Google/Web ☐ Patient/Friend (Name: _____)
☐ Practitioner ☐ Other

PREVIOUS AND CURRENT HEALTH *(Please tick appropriate boxes)*

WHAT ARE HERE FOR TODAY: _____

_____

HOW LONG HAVE YOU HAD THIS CONDTION? _____

IS IT GETTING: Worse? ☐ Constant? ☐ Come/Goes? ☐ Better? ☐

WHAT MAKES THE COMPLAINT BETTER? _____

HAVE YOU CONSULTED ANYONE ABOUT YOUR PROBLEM? Yes ☐ No ☐ Who:_____

WHAT WAS THE DIAGNOSIS? _____

WHAT WAS THE TREATMENT? _____

HAVE YOU EVER HAD THESE SYMPTOMS BEFORE? ? Yes ☐ No ☐

If yes, what caused them previously? _____

HAVE YOU EVER HAD A SERIOUS HEALTH PROBLEM? Yes ☐ No ☐

If yes, please describe: _____

HAVE YOU EVER HAD ANY SURGERY? Yes ☐ No ☐

*If yes, please list:*_____

HAVE YOU EVER HAD ANY ACCIDENTS (E.G MVA OR FALLS OR BROKEN BONES)? Yes ☐ No ☐

If yes, please list: _____

ARE YOU CURRENTLY A SMOKER? Yes ☐ No ☐

HAVE YOU HAD ANY X -RAYS OR ANY OTHER IMAGING IN THE PAST? Yes ☐ No ☐

*If yes, please specify which body parts:*_____

DO YOU HAVE ANY ALLERGIES TO LINSEED/FLAXSEED OR ADHESIVE TAPE? Yes ☐ No ☐

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST WEEK? (Please tick if yes)

Double Vision ☐
Drop Attacks ☐
Difficulty Swallowing ☐
Nausea ☐
Dizziness/vertigo ☐
Speech problems ☐
Difficulty walking ☐
Numbness on one side ☐

PLEASE TURN OVER

HAVE YOU BEEN TAKING ANY DRUGS OR MEDICATIONS? (Please tick)

Anti - Inflammatory	☐	Anti - Depressants	☐
Pain Killers	☐	Blood Thinners	☐
Muscles Relaxants	☐	Birth Control	☐

If other, please list: _____

ARE YOU TAKING ANY SUPPLEMENTS (VITAMINS/MINERALS)? Yes ☐ No ☐

If yes, please list: _____

HOW OFTEN DO YOU EXERCISE? Never ☐ Rarely ☐ Sometimes ☐ Regularly ☐

Please list your hobbies/sports: _____

HAVE YOU EVER SEEN AN OSTEOPATH OR CHIROPRACTOR BEFORE? Yes ☐ No ☐

IS THERE A FAMILY HISTORY OF?

Stroke ☐	Obesity ☐	Osteoporosis ☐
Cancer ☐	Alzheimer's ☐	Eating disorder ☐
Heart attack ☐	Diabetes ☐	Immune Deficiency? ☐

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (Please tick if yes)

☐ Head/face pain	☐ General swelling	☐ Indigestion	☐ Low back pain
☐ Headache	☐ Neck pain/symptoms	☐ Ulcer	☐ Buttock pain
☐ Dizziness	☐ Shoulder pain	☐ Heartburn	☐ Hip joint stiffness
☐ Nausea/vomiting	☐ Arm/elbow pain	☐ Midback symptoms/pain	☐ Leg pain
☐ Loss of concentration	☐ Arm weakness	☐ Rib pain	☐ Leg Weakness/Numbness
☐ Sinusitis	☐ Hand/wrist pain	☐ Constipation	☐ Knee Problems
☐ Hay fever	☐ Finger numbness	☐ Abdominal pain	☐ Calf cramping
☐ Loss of taste/smell	☐ Blood pressure	☐ Kidney disorder	☐ Ankle swelling
☐ Chronic cough	☐ Chest pain	☐ Urinary problem	☐ Ankle/foot weakness
☐ Asthma	☐ Shortness of breath	☐ Skin Problems	☐ Foot/toe numbness

Please circle the number below indicating your pain level right now.

0 1 2 3 4 5 6 7 8 9 10

On the diagram below please indicate where you are experiencing symptoms