New Patient Health History Form

Christchurch Wellness Centre
Chiropractic & Health

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name: _____Date: _____Email: _____

Your email will NOT be shared with any 3rd parties and is used for occasional office announcements and promotions.

How did you hear about us? _____

Mailing Address

Address: _____ City: _____ State: _____
Zip Code: _____ Telephone (Work): _____ (Home): _____ Age: _____
Date of Birth: _____ NHI: _____ No. of Children: _____Occupation: _____
Employer: _____ Marital Status: _____ Spouse's Name: _____
Spouse's Occupation: _____ Spouse's Employer: _____
Spouse's Health Status: _____Emergency Contact: _____ Phone: _____

Current Complaints

Nature of Injury: Automobile / Work / Other

Please Describe _____

Date of Injury: _____ Date Symptoms Appeared: _____

Have you ever had the same condition? Yes / No If yes, when? _____

List other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? Yes / No

If yes, please describe_____

Medical History

Have you been treated for any conditions in the last year? Yes / No Who is your GP? _____
If yes, please describe _____
Date of last physical exam: _____ Is there a chance that you are pregnant? Yes / No
Have you had X-rays taken? Yes / No If yes, where? _____
What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

_____
_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage and frequency)

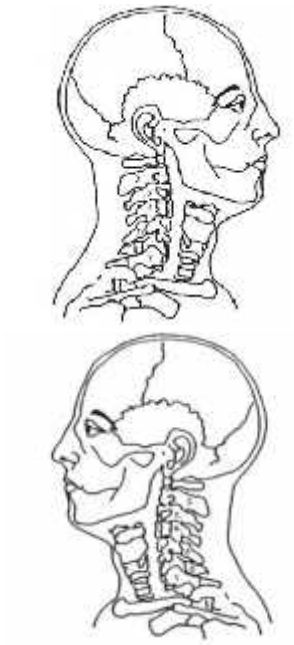
_____
_____
_____

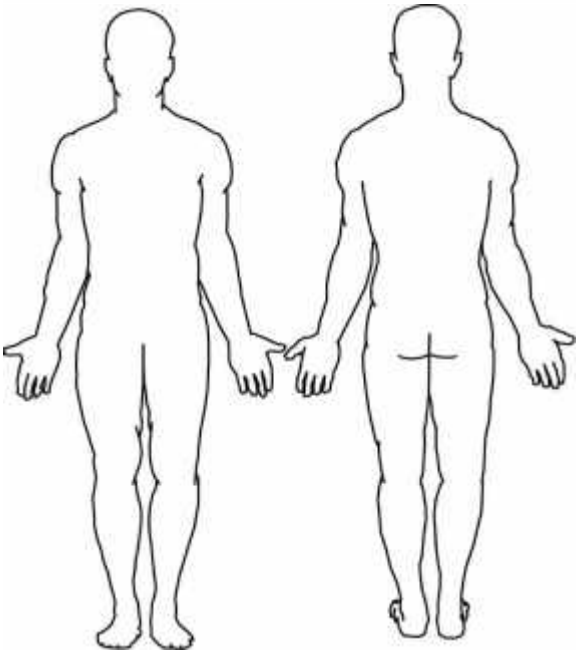
Have you suffered with any of the following in the last 2 years? (Please Circle)

Alcoholism
Allergies
Anaemia
Arteriosclerosis
Arthritis
Asthma
Back Pain
Breast Lump
Bronchitis
Bruise Easily
Cancer
Chest Pain/Conditions
Cold Extremities
Constipation
Cramps
Depression
Diabetes
Digestion Problems
Dizziness
Ears Ring
Excessive Menstruation
Eye Pain/Difficulties
Fatigue
Frequent Urination
Headache
Haemorrhoids
High Blood Pressure
Hot Flushes
Irregular Heart Beat
Irregular Cycle
Kidney Infection
Kidney Stones
Loss of Memory
Loss of Balance
Loss of Smell
Loss of Taste
Neck Pain or Stiffness
Nervousness
Nosebleeds
Pacemaker
Polio
Poor Posture
Prostate Trouble
Sciatica
Shortness of Breath
Sinus Infection
Sleep Problems/Insomnia
Spinal Curvatures
Stroke
Swelling of Ankles
Swollen Joints
Thyroid Condition
Tuberculosis
Ulcers
Varicose Veins
Venereal Disease
Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A= Ache **O=Other**
B= Burning **P= Pins & Needles**
N= Numbness **S= Stabbing**





AUTHORISATION FOR CARE

As with all health care professionals the law now requires practitioners who adjust the spine to inform patients of material risk.

Chiropractic adjustments of the spine are internationally recognised as being safer in dealing with neck and low back pain than medication and many other alternatives (A risk assessment of cervical manipulation, JMPT, 1995. Magna Report, Ontario Ministry of Health 1993).

In extremely rare circumstances some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke like symptoms. This is extremely rare occurring in **approx. 1 in 5.85 million** (Haldeman, et al. Spine, 1999, Vol 24-8). Whilst this has never occurred in this practice, we are still required to impart this information. Before you receive any adjustments, you will be tested to minimise risk, as has always been our practice.

If you have any questions related to the care you are about to receive please speak to the chiropractor.

X-Rays may be required in order to complete our examination and give us the most detailed information about the health of your spine.

For safety purposes, female patients please answer the following questions:

Are you pregnant or trying to get pregnant? Yes / No

When was your most recent period? _____

Please sign below if you give permission for the chiropractor to examine and administer care as deemed necessary. For patients under the age of 18, a parental guardian must sign below.

Signature: _____

Date: _____

Have you ever?	Yes / No	Briefly Explain
Broken bones?	Yes / No	_____
Been hospitalized?	Yes / No	_____
Been in an auto accident?	Yes / No	_____
Had Sprains/Strains?	Yes / No	_____
Been struck unconscious?	Yes / No	_____
Had surgery?	Yes / No	_____

Family History	
Family Member	**Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you experience pain every day?	Yes / No
Do your symptoms interfere with daily life?	Yes / No
Does pain wake you up at night?	Yes / No
Are your symptoms worse during certain times of the day?	Yes / No
Do changes in weather affect your symptoms?	Yes / No
Do you wear orthotics?	Yes / No
Do you take vitamin supplements?	Yes / No
What activities aggravate your symptoms?	Yes / No

Habits	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				