thewellnesschiropractor™

NEW PATIENT INTAKE FORM

In order to provide you the best possible care, please complete this form thoroughly. All information is strictly CONFIDENTIAL and we comply with Australian privacy laws.

Patient name: _____ **Birthdate:** _____ **Age:** _____

Preferred name: _____

Home address: _____

_____

Home phone: _____ **Mobile phone:** _____

Email address: _____@_____

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

How did you find out about us? _____

Emergency contact: _____ **Phone:** _____

Emergency contact's relationship to you: _____

Current work status: ____ Employed ____ Retired ____ Not working ____ Light Duty

Occupation: _____

What are you seeing the chiropractor for? ☐ Back pain ☐ Neck pain ☐ Headache ☐ Other

Have you seen a medical doctor in the past for these conditions?

Doctor: _____ **Date:** _____ **Treatment:** _____

Doctor: _____ **Date:** _____ **Treatment:** _____

SPINAL IMAGING

Have you had any medical imaging of your <u>SPINE and/or PELVIS</u> taken in the past?

Imaging type (x-ray, CT, MRI, etc.)	Details (date, results, etc.)

MEDICATIONS

MEDICATIONS	DOSE

ALLERGIES

ALLERGY	SEVERITY (MILD, MODERATE, SEVERE)

PAST SURGERIES

SURGERY	DATE

BACK PAIN (Complete this section if applicable)

Location:

_____ No back pain
_____ Centrally located low back pain
_____ Right sided low back pain
_____ Left sided low back pain
_____ Both sides into the hips
_____ Between the shoulder blades

Describe your pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your back pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to legs/feet/toes
_____ Radiates into the right leg
_____ Radiates into the left leg
_____ Radiates into the right foot/toes
_____ Radiates into the left foot/toes

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Flexion (bending forward)
_____ Extension (bending backwards)
_____ Rotating left / right
_____ Laying on back
_____ Coughing / sneezing
_____ Laying on side
_____ Motion

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Exercise and stretching
_____ Rest
_____ Laying on side
_____ Laying on back

NECK PAIN (Complete this section if applicable)

Location:

_____ No neck pain
_____ Centrally located low neck pain
_____ Right sided low neck pain
_____ Left sided low neck pain
_____ Both sides into the shoulders
_____ At the base of the skull

Describe your pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your neck pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for neck pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to arms/hands/fingers
_____ Radiates into the right arm
_____ Radiates into the left arm
_____ Radiates into the right fingers
_____ Radiates into the left fingers

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Moving head up
_____ Moving head down
_____ Rotating left / right
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

HEADACHES (Complete this section if applicable)

Location:

_____ No headaches
_____ Forehead
_____ Right side of head
_____ Left side of head
_____ Behind the eyes
_____ Back of head

Describe your pain:

_____ Deep pressure
_____ Dull ache
_____ Burning
_____ Throbbing
_____ Hot/tingling
_____ Stiff and sore

When did your headaches begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Frequency:

_____ per week

History:

_____ History of headaches?
_____ Ever suffered a concussion?
_____ Prior epilepsy treatment?
_____ Prior history of seizures?

What makes your pain worse?

_____ Noise
_____ Light
_____ Food
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

OTHER PAIN (Complete this section if applicable)

Location:

_____

Describe your pain:

_____

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

When did your pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for your pain?

_____ Yes _____ No

Does your pain radiate?

_____

How well do you function with your pain?

_____

What makes your pain worse?

_____

What makes your pain better?

_____

REVIEW OF SYSTEMS

Have you noticed any of the following?

_____ Unexpected weight loss or gain
_____ Blurred / double vision
_____ Headache
_____ Chest pain
_____ Shortness of breath
_____ Nausea
_____ Painful urination
_____ Joint pains
_____ Skin rash
_____ Dizziness
_____ Depression
_____ Easy bruising
_____ Excessive thirst or urination
_____ Reaction to foods / environment

PAST MEDICAL HISTORY

Have you had any of the following?

_____ Hypertension
_____ Coronary Artery Disease
_____ Arthritis
_____ Cancer
_____ Overweight
_____ Osteoporosis
_____ Immune Disorder
_____ Other: _____

Do you consume alcohol?

_____ I do not drink _____ I am a recovering alcoholic _____ I drink occasionally

Do you smoke?

_____ Yes _____ No _____ I used to smoke

Do you use recreational drugs?

_____ No _____ I have previously used _____ I currently use

FAMILY HISTORY

Has anyone in your immediate family ever had the following?

_____ Cancer
_____ Stroke
_____ Hypertension
_____ Alcoholism
_____ Bleeding tendency
_____ Other: _____

PREVIOUS CHIROPRACTIC CARE

Have you received chiropractic care in the past?

☐ Regularly ☐ Occasionally ☐ A few times ☐ Just once ☐ Never

If yes, what was the reason? _____

How do you rate the result?

☐ Excellent ☐ Good ☐ Fair ☐ No change ☐ I got worse

What is the approximate date of your last chiropractic visit? _____

EXPLANATION OF SERVICES

Chiropractic is concerned with the relationship between the spinal column and the nervous system as it affects the restoration and maintenance of health; primarily utilising the hands to adjust vertebral subluxations.

These subluxations create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort, and/or a lessening of the body's ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Chiropractic care is different to medical treatment. Our primary focus is providing our patients with a pathway towards better health; not the treatment of disease and illness.

Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients that we determine to have the potential to benefit from our care.

FINANCIAL RESPONSIBILITY

All patients understand and agree that Dr. Greg Kendall | The Wellness Chiropractor does not accept patients seeking care under any third party payor schemes such as, but not limited to, WorkSafe, WorkCover, TAC or Medicare.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them.

Everything I have answered is true and correct to the best of my knowledge. I have read and fully understand the above statements.

Patient Signature: _____ Date: _____

CONSENT TO PROVIDE CHIROPRACTIC CARE TO A MINOR

As parent or legal guardian of _____
(Minor's Name)

I confirm that everything answered is true and correct to the best of my knowledge. I have read and fully understand the above statements. I hereby grant permission for my child to receive chiropractic care.

Parent or Legal Guardian Signature: _____ Date: _____