NEW PATIENT INFORMATION

Welcome to Pinnacle Chiropractic Health Group! Please take your time to complete ALL questions.

Name appearing on NRIC/passport: Surname _____ First: _____

Title: Dr/Mr/Mrs/Ms/Miss (circle)NRIC/passport number: _____

Address: _____

Postcode: _____ email _____

Home Phone: _____ Mobile: _____

Marital Status: S/M/D/W Gender: ☐ Male ☐ Female

Date of Birth: _____ Age: _____

Occupation: _____ Employer _____

Partner's Name: _____ Partner's Occupation _____

Children's Names & Ages: _____

Who may we thank for referring you? _____

or where did you hear about us: _____

Brochure / Yellow Pages/ Talk / Exhibition / Website / Newspaper / Other: _____

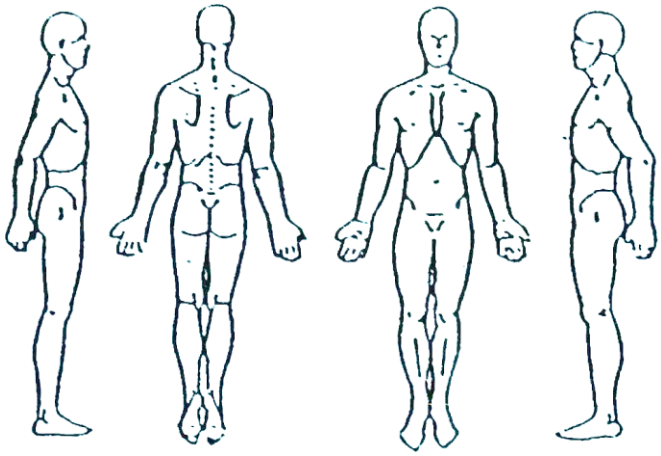
Have you been to a chiropractor before? ☐ Yes ☐ No

If YES, who? _____ When was your last adjustment? _____

Our centre is a unique, CORRECTIVE chiropractic centre. We look for SUBLUXATION PATTERNS in the spine, which inevitably, and eventually, lead to symptoms. Please tick any of the following symptoms you have experienced at any time in the past twelve months:

☐ Neck Pain/Stiff neck	☐ Numbing/Tingling in legs or feet	☐ Depression
☐ Numbing/Tingling in arms or hands	☐ Dizziness	☐ Allergies
☐ Headaches /Migraine	☐ Ringing in Ears	☐ Recurrent colds or flu
☐ Pain between shoulder blades	☐ Breathing problems/Asthma	☐ Digestive Problems
☐ Shoulder tension/Pain	☐ Tiredness/Fatigue	☐ Weight Problems
☐ Low Back Pain	☐ Difficulty Sleeping	☐ Menstrual Problems
☐ Hip pain (left/right/both)	☐ Nervousness	☐ Tension/Irritability

Please circle area of concern:



Which of the above symptoms affects your life the most?

_____

How often does it occur?

_____ x/week

_____ x/month_____

_____ x/year

Rated on a scale of 1 to 10, (10 being the worst pain)_____ /10

Are you consulting our office for a (tick): ☐ wellness evaluation OR ☐ specific health concern

Does this cause you to be:	How does this affect your work?	How does this affect your life?
☐ Moody?	☐ In decision making?	☐ Do you lose patience with your spouse and/or children?
☐ Irritable?	☐ Results in a poor attitude?	☐ Are you restricted in household duties?
☐ Have interrupted sleep?	☐ Results in decreased productivity?	☐ Is your ability to exercise or participate in sport hindered?
☐ Restricted in daily activities?	☐ Are you exhausted at the end of the day?	☐ Does it interfere with your ability to participate in hobbies or other desired activities?

Health Habits:

Do you smoke? ☐ Yes ☐ No - If yes: approx. cigarettes per day? ____ week?____
Do you drink alcohol? ☐ Yes ☐ No - If yes: approx. Drinks per day?____ week?_____
Do you drink coffee? ☐ Yes ☐ No - if yes: approx. Cups per day? ____ week?____
Do you exercise regularly? ☐ No ☐ Occasional ☐ Daily
Do you wear(Circle one): High heels/Foot orthotics/heel lifts/arch supports
How would you rate your current diet? ☐ excellent ☐good ☐fair ☐poor

Please list your current health goals(for physical, emotional, spiritual, mental, etc)

I want to _____ by_____(optional)

1) _____

2) _____

PLEASE LIST ALL PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING, AS WELL AS SURGERIES YOU HAVE HAD IN YOUR LIFETIME

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING THAT HAVE BEEN PRESCRIBED BY A MEDICAL PRACTITIONER, AND THE CONDITION FOR WHICH YOU ARE TAKING THEM (e.g. Blood Pressure, Depression, Cholesterol etc)	HAVE YOU HAD ANY OPERATIONS OR SURGERIES IN YOUR LIFETIME? PLEASE LIST THE TYPE OF SURGERY AND YOUR APPROXIMATE AGE AT THE TIME (e.g. Tonsils – Age 5, Appendix – Age 14 etc)