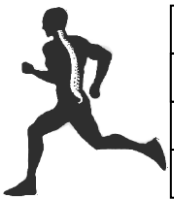
# Lawrence Chiropractic Clinics



| CASE NUMBER |
| --- |
| |
| DATE |
| |

## NEW PATIENT DETAILS FORM

*Quality Care for a Fitter Future*

**TO BE COMPLETED BY PATIENT**

All details are confidential and will not be shared with any third party without written consent

PLEASE WRITE CLEARLY IN BLOCK CAPITALS

Surname: _____ Mr, Mrs, Ms, Miss, Other: _____ Age: _____

Forename(s): _____ Date of Birth: _____

Full Address: _____

_____ Post Code: _____

Email: _____ Marital Status: _____

Names and ages of children: _____

Mobile: _____ Home: _____ Work: _____

How did you find out about the clinic (please be specific): _____

EMPLOYMENT DETAILS

Occupation: _____ Number of years in current job: _____

Employer: _____

HEALTH DETAILS

Name of GP: _____ Telephone number: _____

Address of GP: _____

ADDRESSING WHAT BOUGHT YOU INTO THIS OFFICE

| What are the main reasons for this appointment? | Severity (mild 0-10 worst) | Has this happened before? |
| --- | --- | --- |
| 1. _____ | _____ | Y / N When? _____ |
| 2. _____ | _____ | Y / N When? _____ |
| 3. _____ | _____ | Y / N When? _____ |
| 4. _____ | _____ | Y / N When? _____ |

Elaborate: _____

_____

_____

_____

_____

When did you first notice these problems? _____ Was it Sudden OR Gradual? _____

Do you believe any event/illness contributed to this? Y / N Explain: _____

_____

Are these conditions interfering with any of the following? Work / Sleep / Digestion / Daily Routine / Sports / Other

Please Explain: _____

## GENERAL HEALTH

Have you had ANY sprains, broken bones, major falls or surgery (including dental)? Y / N

Type:_____When/Age?_____

Type:_____When/Age?_____

Type:_____When/Age?_____

Type:_____When/Age?_____

Have you had any accidents and/or injuries: car, sports or other especially related to your current problems)?

Type:_____When/Age?_____

Type:_____When/Age?_____

Type:_____When/Age?_____

Type:_____When/Age?_____

**Please circle the appropriate answer for each of the following questions: DO YOU:-**

| | | | | |
|---|---|---|---|---|
| Exercise? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Play contact sports? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Sit for long periods? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Regularly bend & lift? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |
| Spend over 2 hours per day at a computer? | Yes, daily/almost daily | Occasionally | Not at all | Did in the past |

**Poor posture leads to poor health and often indicates a spinal problem. How do you rate your posture?**

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

## DIET

In as much detail as possible, please describe your typical daily diet

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Fluids:_____

How many cups of coffee/tea do you drink per day?_____Do you smoke Y / N How many per day? _____

## CURRENT MEDICATION

Have you been taking any medications/drugs (prescription/non-prescription) in the last 12 months?

Name:_____Dose/Frequency:_____Why?_____

Name:_____Dose/Frequency:_____Why?_____

Name:_____Dose/Frequency:_____Why?_____

Name:_____Dose/Frequency:_____Why?_____

Name:_____Dose/Frequency:_____Why?_____

Name:_____Dose/Frequency:_____Why?_____

**From childhood to present, have you ever had any of the following (tick the box of any that apply)?**

- ☐ Kidney problems
- ☐ Liver problems
- ☐ Heart problems
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lung problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer
- ☐ Migraines
- ☐ Headaches
- ☐ Depression
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Allergies
- ☐ Dizziness
- ☐ Tinnitus
- ☐ Itchy, waxy ears
- ☐ Jaw pain
- ☐ Clicking jaw
- ☐ IBS
- ☐ Circulation problems
- ☐ Vomiting
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Gall bladder problems
- ☐ Gas/bloating after meals
- ☐ Heartburn
- ☐ Black/bloody stool
- ☐ Bladder trouble
- ☐ Urinary tract infections
- ☐ Fatigue
- ☐ Loss of sleep
- ☐ Shingles

Men Only

- ☐ Prostate dysfunction
- ☐ Sexual dysfunction
- ☐ Testicular pain
- ☐ Testicular lumps

Women Only

- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain/infections
- ☐ Breast pain/lumps

When was your last period? / /

Are you pregnant? Y / N

## HEALTH STATUS

**Rate out of 10 (1 = poor, 10 = outstanding) your level of satisfaction in your…**

Flexibility
1.2.3.4.5.6.7.8.9.10

Digestion
1.2.3.4.5.6.7.8.9.10

Energy levels
1.2.3.4.5.6.7.8.9.10

Stress
1.2.3.4.5.6.7.8.9.10

Sleep quality
1.2.3.4.5.6.7.8.9.10

Ability to recover from stressful events
1.2.3.4.5.6.7.8.9.10

Posture
1.2.3.4.5.6.7.8.9.10

Immune system function
1.2.3.4.5.6.7.8.9.10

Exercise frequency
1.2.3.4.5.6.7.8.9.10

Overall health
1.2.3.4.5.6.7.8.9.10

## HEALTH GOALS

**Which of these health goals is most important to you?**

1.) Pain control/relief 2.) Energy level and fatigue 3.) Quality of sleep 4.) Memory and ability to focus

4.) Digestion 5.) Nutrition 6.) Mood 7.) Stress levels 8.) Allergies and immune system

9.) Understanding more about health and how you and your family can keep healthy

**What would you like to be able to do that your current condition is preventing you from doing?** _____

_____

_____

**Have you been forced to make positive changes in your life due to this condition (e.g. eating better, increased exercise, less alcohol or drugs, avoiding contact sports etc)? If yes, what?**_____

_____

**HEALTH INSURANCE**

We are registered with most health insurance companies. If you are claiming your treatment or part of your treatment cost through your health insurance company it is your responsibility to check prior to treatment what and how much is covered. Some insurance companies require GP referral and/or an authorisation number before treatment costs can be claimed.

Do you wish to claim through your health insurance company? Y / N

Health insurance company: _____

Policy Number: _____

Authorisation code: _____

**INFORMED CONSENT**

There are many concerns about the safety of procedures we undergo routinely, the environment we live in and the food we consume but to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Lawrence Chiropractic Clinics will enhance your experience. Some people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care.

If you are [or have been] taking anticoagulant [blood thinning] medication or steroids then it is important to tell your chiropractor this prior to commencing care.

There are always risks associated with any therapeutic intervention. The risk of permanent injury from manual spinal adjustment is approximately 1 in 2.5 million. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or paracetamol for aches and pains is approximately 1 in 333. Statistically there is more chance of being hit by lightning than experiencing permanent damage from a manual adjustment. We must explain these risks to you so that you can make an informed decision about commencing or continuing your care. If you have any further concerns please ask your chiropractor.

The adjustments and care you receive here at Lawrence Chiropractic Clinics will be tailored to your specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. Our range of techniques provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.

I have read the above and give authority to Lawrence Chiropractic Clinic to commence/continue chiropractic care for either myself or my dependent [whichever is applicable].

Name (Please Print):_____

Signed:_____ Date_____