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: ____

____

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____

____

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? _____

Do you drink alcohol? Yes / No. How many days per week?____How many units per week on average?_______

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
- ☐ Migraines
- ☐ Headaches
- ☐ Clicking jaw
- ☐ Depression
- ☐ 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? ________________

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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?________________

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