New Client - ADULT

Welcome to Coast to Country Chiropractic and Thank You for Choosing Us

SURNAME:_____ **First Name (s):** _____ Gender: M / F

Preferred Name: _____ Date Of Birth: / / Age: _____ Occupation: _____

Postal Address: _____ Suburb: _____ Post Code: _____

Contact Telephone Numbers: (Home) _____ (Mobile) _____ (Work) _____

Email Address*_____ No. of Children _____

Next of Kin (NOK) Name: Relationship to You:

NOK Address: _____ Suburb: _____ Post Code: _____

NOK Contact Numbers: (Home) (Mobile)

Concession Card Number: Exp Date: DVA Number: ○ Gold ○ White

Medical Doctor's Name: Location of Doctor:

Private Health Fund:

How did you find our clinic? ○ Billboard ○ Signage ○ Car Signage ○ Gatton Star ○ Other Newspaper ○ Yellow Pages ○ Internet/Website ○ Facebook ○ Family/Friend ○ Events/Expo ○ Radio ○ Personal Training ○ Other (please describe):

_____

If we were recommended, please state who recommended us: _____

May we use your name to thank them? ○ Yes ○ No

Have you ever received chiropractic care before? ○ Yes ○ No

If yes, when was your last visit? _____

Name of Chiropractor: _____

Have you ever had **massage** treatment before? ○ Yes ○ No

What is your main reason for seeking treatment?

_____

How long have you had this complaint? _____

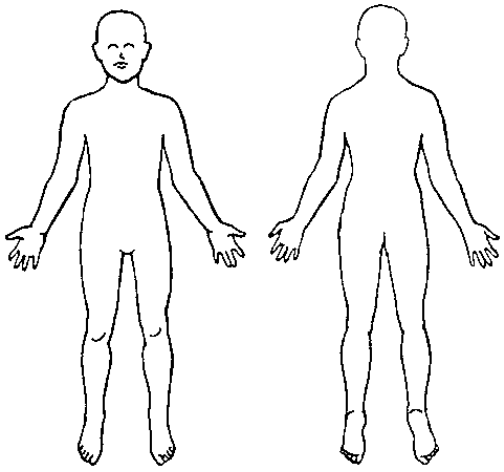
Have you had a similar complaint before? ○ Yes ○ No

Is it: ○ Getting worse ○ The same ○ Getting better ○ Coming & going

What makes it better? _____

What makes it worse? _____

(Please colour in your pain areas)



On a scale of 1 to 10 (1 = no problem, 10 = severe), how would you rate your pain:

Now 1 2 3 4 5 6 7 8 9 10 **At its worst?** 1 2 3 4 5 6 7 8 9 10

Where do you want it to be? 1 2 3 4 5 6 7 8 9 10

What have you tried already to fix this problem? _____

Why did you stop? Cost Time Other Commitments Didn't Work Other Reasons: _____

What <u>specifically</u> do you want from your treatment? _____

When you've achieved this, how will it make you feel? _____

How serious are you about fixing this problem? Not – 1 2 3 4 5 6 7 8 9 10 - Completely

Have you ever tried Personal Training? YES / NO Would you be interested in talking with our PT? Yes / NO / Later

*Coast to Country can issue appointment reminders as well as information and offers via email, if you do not wish to receive these emails from us please leave this field blank. We respect your privacy and do not release any client information to third parties without your consent.

Please Turn Over

WHAT FACTORS COULD POSSIBLY STOP YOU FROM COMPLETING A RECOMMENDED TREATMENT PLAN?

ABOUT YOUR HEALTH HISTORY

Answering the following questions will help us to review important aspects of your health history and lifestyle. This will enable us to best determine how we may help you to achieve better levels of health and well being.

DO YOU HAVE, OR HAVE YOU EVER HAD, PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE TICK IF THE ANSWER IS YES.

O ALLERGIES	O CIRCULATION	O LACK OF ENERGY	O URINARY PROBLEMS
O ABDOMEN	O DIARRHOEA	O LOW IMMUNE SYSTEM	O VARICOSE VEINS
O ANXIETY/DEPRESSION	O DIZZINESS / BLACKOUTS	O LUNGS	O VISUAL PROBLEMS
O ARMS OR LEGS	O EARS / HEARING	O MULTIPLE SCLEROSIS	O WHIPLASH
O ARTHRITIS / JOINT SWELLING	O EATING DISORDERS	O NUMBING OR STABBING PAIN	**FOR MEN ONLY:**
O ASTHMA	O ECZEMA	O PANCREAS / SUGAR LEVELS / DIABETES	O FERTILITY
O BALANCE	O EPILEPSY / SEIZURES	O PSYCHIATRIC PROBLEMS	O GENITALS
O BACK PAIN	O FIBROMYALGIA	O SENSATION CHANGES	O PROSTATE
O BLOOD DISORDERS	O FEVERS / SWEATS / CHILLS	O SPORTS INJURIES	**FOR WOMEN ONLY:**
O BLOOD PRESSURE	O HEADACHES / MIGRAINES	O STRESS	O BREASTS
O BOWEL / INTESTINES	O HAY FEVER / SINUSES	O STROKE	O FERTILITY
O BRUISING EASILY	O GALL BLADDER / LIVER	O TREMORS	O MENOPAUSE
O CHEST PAINS	O HEART DISEASE	O TONSILLITIS	O OVARIES / UTERUS
O COUGHING	O HEPATITIS / HIV+	O ULCERS	O MENSTRUAL PROBLEMS

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE PROVIDE FURTHER INFORMATION:

DO YOU HAVE A PACEMAKER? O YES O NO ARE YOU PREGNANT? O YES O NO IF YES, HOW MANY WEEKS? ___

HAVE YOU HAD CORTISONE INJECTIONS WITHIN THE PAST 12 MTHS O YES O NO

HAVE YOU HAD X-RAYS OF YOUR SPINE IN THE PAST 5 YEARS? O YES O NO

ARE YOU, OR HAVE YOU EVER BEEN, A SMOKER? O YES O NO HOW LONG AGO DID YOU QUIT? _____

HAVE YOU EVER HAD A STROKE? O YES O NO

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? O YES O NO _____

HAVE YOU EVER BEEN IN A MOTOR VEHICLE ACCIDENT? O YES O NO _____

HAVE YOU EVER HAD ANY FRACTURES/DISLOCATIONS? O YES O NO _____

PLEASE LIST ALL PREVIOUS SURGERY: _____

PLEASE LIST ALL PRESCRIBED MEDICATIONS: _____

PLEASE LIST ALL VITAMIN AND MINERAL SUPPLEMENTS:

DO YOU HAVE ANY FAMILY HISTORY OF THE FOLLOWING? PLEASE TICK IF YES

O HIGH CHOLESTEROL	O HEART DISEASE	O RHEUMATOID ARTHRITIS
O BLOOD PRESSURE	O KIDNEY DISEASE	O PSORIATIC ARTHRITIS
O DIABETES	O OSTEOPOROSIS (THIN BONES)	O CANCER & TYPE:
	O MIGRAINES	

WILL YOU BE CLAIMING WORKERS COMPENSATION O YES O NO OR DEPARTMENT OF VETERAN'S AFFAIRS O YES O NO

YOUR HEALTH OBJECTIVES

People consult this office with one or more of the following health objectives.
Please tick those which apply to you.

O CORRECTION OF THE UNDERLYING CAUSES OF MY SYMPTOMS AND HEALTH PROBLEMS
O PREVENTION OF THE DEVELOPMENT OF SYMPTOMS, HEALTH PROBLEMS AND DEGENERATION
O ACHIEVEMENT OF AN OPTIMAL LEVEL OF HEALTH AND WELL BEING FOR MYSELF
O OPTIMAL HEALTH AND WELL BEING FOR MY WHOLE FAMILY

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND I HAVE NOT KNOWINGLY WITHHELD ANY INFORMATION THAT IS RELEVANT TO MY HEALTH AND TREATMENT.

CLIENT SIGNATURE		DATE	