New Patient Examination Form

Title: First Name: Surname:

Address: Occupation:

Post Code: Tel (Home):

E-mail: Mobile:

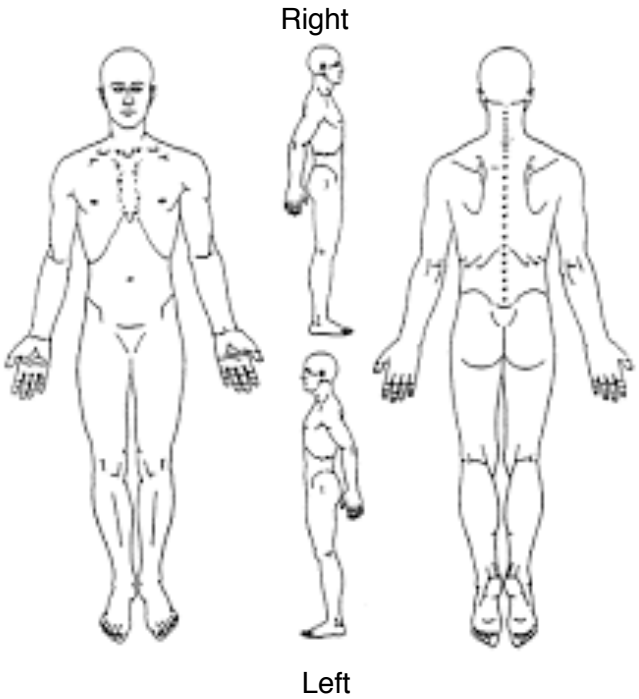
May we contact via email or text? Date of Birth:

Yes / No Age:

GP Name & Address:

How did you hear about Pink Chiropractic Clinics?

Please mark your MAIN area of complaint (X) and where the pain travels (if it does):



What describes the nature of your symptoms? Please circle:

Sharp / Numb / Burning / Dull Ache / Shooting / Tingling

Please indicate your average pain during the week out of 10 where
No Pain = 0 , Max Pain = 10

Your Pain level: /10

Does the pain wake you up at night?

Yes / No

May we contact your GP if necessary?

Yes / No

Please list all medications you are taking presently:

Main Area of Compaint:

When did it start and have you had it before?

What could have caused it?

What makes it better?

What makes it worse?

Any previous treatment?

MEDICAL HISTORY

Have you been to see your GP about the pain? If so, what was diagnosis/treatment?

Have you had any surgery? If yes, please list.

Any broken bones? Please list.

Any accidents (car, falls, sports injuries, etc) ?

Are you currently attending hospital or seeing a doctor? Please elaborate.

Are you awaiting any major diagnostic tests or treatments? (X-rays, MRIs, CT Scans, Chemo)

Do you suffer from headaches? If yes, how often?

Do you consider yourself to be under stress? (Financial, work, relationships, family, etc)

Any major dental work recently?

If applicable, are you pregnant? Yes / No

Any of the following problems? Please circle.

Abdominal pain	Cramp	Joint pain
Angina	Circulation	Kidney problems
Appetite loss/gain	Depression	Liver problems
Arthritis	Diabetes	Mental Illness
Asthma	Dizziness	Night Sweats
Bladder problems	Ear / Hearing	Prostate
Blood Pressure (high / low)	Endometriosis	Headaches / Migraines
Cancer (Type):	Epilepsy	Heart Problems
Chest Pain	Fainting	Eye Problems
		Thyroid

I consent to being examined & treated.

Signed :_____ Date: _____