New Patient Registration Form

Please complete the front and back pages of this form

Today's Date:

Mr/Mrs/Miss/Ms/Other:

Surname:

First Name(s):

Date of Birth: **Age:**

Address:

Post code:

Telephone numbers: (only include if it is appropriate to call you on this number)

Home:

Mobile:

Work:

Email address:

Emergency contact – Name: **Tel:** **Relationship to you:**

Do you have children? Yes / No. If yes what age are your children?

Occupation:

Activities/Hobbies:

How did you hear about us? Internet / Yellow pages / GP / Specialist / Friend / Relative / Walked past

GP name and practice address:

It is our policy to contact your GP when appropriate. Do you give your consent? Yes / No

Do you see any other Healthcare Practitioner? Please give details

Do you have private health insurance? Yes / No If Yes what company is your insurance with?

Have you received chiropractic treatment before? Yes / No If Yes Practice/Chiropractor's name:

Please list and describe the problems for which you seek Chiropractic care:

Main problem:

Any other problem/s

Please list all medications/ painkillers/ supplements (tablets/ointments/lotions) you currently take/use:

Please list any medications you have previously taken:

Please list anything including medications that you are allergic to or react badly to.

Have you ever been hospitalised or had any operations at all? Please give details and dates if possible.

Have you ever had X-rays/ MRI / CT /Ultrasound scans? Please state of what part of you and dates if possible.

Have you ever had any accidents/injuries/ road traffic collisions? Please give details and dates if possible.

Have you ever broken any bones? Please give details and dates

Do you smoke? **Yes/No** **If yes, how many per day:**

Do you drink alcohol? **Yes/No** **If yes, how much per week:**

Do you exercise regularly? **Yes/No**

Do you sleep well? **Yes/No**

Do <u>you</u> or any <u>member of your family</u> (please state which family member) experience problems with:

Headaches		**Numbness**		**Cancer**	
Migraines		**Pins and needles**		**Stroke**	
Jaw or dental problems		**Weakness**		**Diabetes**	
Visual problems		**Bowel problems**		**Parkinson's disease**	
Dizziness		**Bladder problems**		**Multiple sclerosis**	
Balance		**Weight loss/gain**		**Osteoporosis**	
Breathing		**Bruising easily**		**Scoliosis**	
Heart/blood pressure		**Memory problems**		**Thyroid problems**	
Indigestion		**Epilepsy**		**Ulcers**	

I have read the clinic's privacy policy – Please place an X in the box ☐