Name ________________ Age ________________ Date

Choma Chiropractic
Confidential New Patient Questionnaire Part A

Have you had previous chiropractic care? Y/N How did you hear about this clinic? ____________________
Do you intend to reclaim fees through insurance? Y/N

Surname____________________ Forename(s)____________________

Address ____

City______________________________Post Code________________

Mobile:____________ E-mail: ________________ Landline: ____________

Date of Birth (DOB)________ Age ____ Marital Status _______ No. of children ______ Pregnant Y/N/Not Applic.

Occupation________________Describe main activities (eg lifting)________________

Years in current job ________ How does your job affect your complaint? ____________________

GP Name ____________ GP Address ______________________________

Have you consulted your GP about any medical condition(s) recently (last 6 months)? ____________________

List tests (eg MRI/bloods) taken in the past year or upcoming:____________________

List any referrals undergone in the past year or upcoming: ____________________

Operations/Hospitalizations (past 5 years): ____

____

Traffic Accidents/Major Traumas/Broken Bones (past 5 years): ____________________

____

Current Medications: ____

____

Height _________ Weight __________ Any unexplained weight loss/gain in the last 3 months? Y/N

Last Cervical Smear Last Menstrual Period Regular Breast/Testicle self examination Y/N
Do you Smoke: _______ Number per day _____ /per ______ years. Do you drink Alcohol: Y/N units per day ___________
FAMILY HISTORY: Circle applicable health issues

Mother's Side: Heart/Lung/Bowel/Bladder/Stomach/Liver/Gallbladder/Pancreas/Reproductive/Skin/Muscle
Joints/Arthritis Cancer Diabetes Nervous (eg MS, Epilepsy) Other:
Father's Side: Heart/Lung/Bowel/Bladder/Stomach/Liver/Gallbladder/Pancreas/Reproductive/Skin/Muscle
Joints/Arthritis Cancer Diabetes Nervous (eg MS, Epilepsy) Other:

SLEEP PATTERNS: Circle applicable

No trouble sleeping
Difficult getting to sleep (due to discomfort)
Can resettle if wake due to discomfort

Usually no trouble sleeping
Difficulty staying asleep (due to discomfort)
Can resettle if wake up due to bathroom trip

Name ______________________ Age ______________________ Date

Part B: Major Complaint

Describe your major complaint(s) or symptom(s):: ______________________

How long have you had the problem this time? ______________________ Do you know what caused the problem?

____

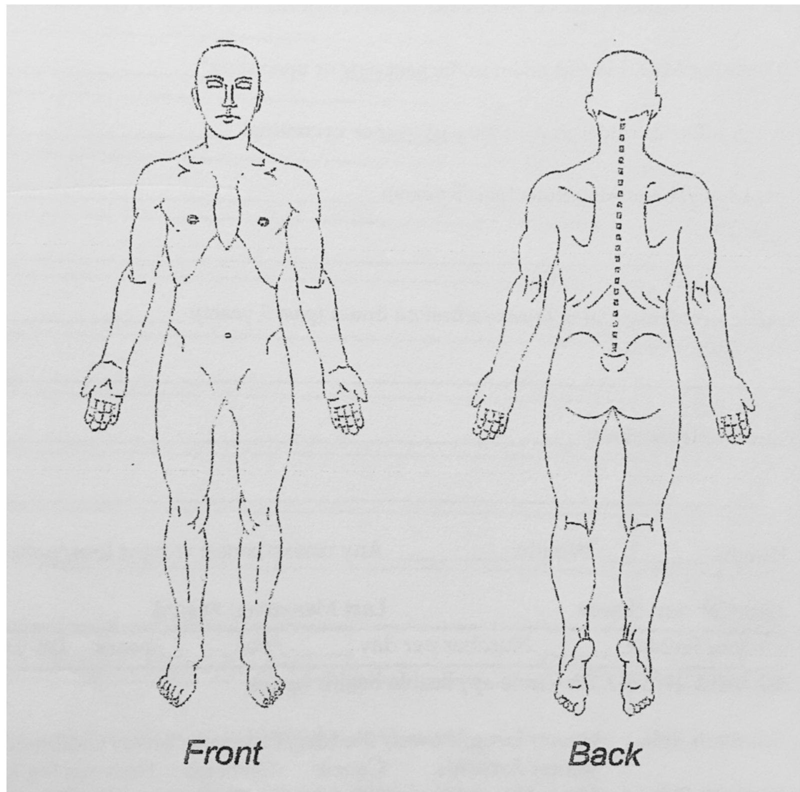
Have you had this problem before? Y/N Did you have treatment? Y/N ____________ Did it help? Y/N

Does pain radiate into your arms or legs? Y/N How Would You Rate Your Pain? 1 =BEST 10 = WORST

Are your symptoms...
Getting better Getting worse Staying the same Come & Go

How would you describe the pain ...
Sharp Dull Aching Burning Throbbing Spasm Numbness
Tingling Shooting Pins and Needles

Does your complaint interfere with ...
Work Sleep Hobbies Daily Routine Other:

<table>
<tr><th><u>Circle regular activities at work/ home:</u></th><th>Mark the areas where you are experiencing the symptoms:</th></tr>
<tr><td>PROLONGUED SITTING
PROLONGUED STANDING
PROLONGUED WALKING
HEAVY LIFTING
REPETITIVE MOTION
BENDING
DRVING
HOUSEWORK
OUTDOOR WORK
SPORTS
DESK/OFFICE
COMPUTER WORK
OTHER</td><td>
</td></tr>
</table>

I confirm that the information given is true to the best of my knowledge and belief. I understand that the chiropractor may wish to undertake an appropriate physical examination to which I hereby consent.

Patient's Signature: ….. Date: …...

(In the case of a child, or a person of diminished intellectual capacity, parent/guardian to sign)