

Barcode

# New Acquaintance Form

# Adult

Name (as on Medicare card):

First Name: «FirstName» Surname: «LastName»

Address: «Address1» «Address2» «Suburb» «State» «Postcode»

Email (required for statements): «PatientsEmail»

Phone (home): «HomePhone» (mobile): «MobilePhone»

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Occupation

How were you referred to Bonfire?

When did you last see a Chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Chiropractic x-rays\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children, if so how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your General Practitioner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications/ drugs you are currently talking, the reason and the dosage:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FEMALE ONLY (FOR X-RAY PURPOSES): Is there any chance of you being pregnant? YES / NO

## Main areas of concern

### Primary Problem

Please describe:

How old were you when the problem started?

What caused it?

On a scale of “0” being nothing and “10” being severe, how would you rate the problem?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is the problem constant/ occasional/ weekly/ monthly/ other?

Do you get referred pain? Yes / No If Yes, where?

What previous treatment have you had?

What makes the problem better?

What makes the problem worse?

### Secondary Problem (if any)

Please describe:

How old were you when the problem started?

On a scale of “0” being nothing and “10” being severe, how would you rate the problem?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is the problem constant/ occasional/ weekly/ monthly/ other?

## Traumas

Please list any incidents that may have had an impact on your spine, from childhood through to today. (Eg. Childhood falls, pregnancy, heavy work, car accidents, sports, etc…)

|  |  |  |
| --- | --- | --- |
| Trauma | Age | Severity (at the time)  0-10 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Safety

It is important in Chiropractic care to make sure the blood vessels in the neck are not showing symptoms that may indicate problems. Have you recently experienced any of the following?

Unsteadiness on your feet or Severe Dizziness YES / NO

Difficulty talking or swallowing YES / NO

Unrelenting Nausea or Vomiting YES / NO

Severe Headaches or Neck Pain unlike ever before YES / NO

Ringing in the ears or Recent Visual Changes YES / NO

Likewise, we are concerned that occasionally patients may have a deteriorating or damaged disc in their lower spine. Have you recently experienced any of the following?

Loss of bowel or bladder control YES / NO

Loss of leg muscle size or numbness in the legs YES / NO

Difficulty standing or progressive weakness in the legs YES / NO

Shooting or sharp pain in the low back or legs when   
coughing or sneezing YES / NO

## General Health History

Any history of bone thinning disease such as osteoporosis,   
or long term corticosteroids? YES / NO

Do you have ANY health problems  
(e.g. Diabetes, asthma, cancer, high blood pressure, etc…)? YES / NO

Any recent large loss of weight? YES / NO

Have you any implants, surgical clips, or foreign bodies   
such as pace-makers? YES / NO

Do you give permission for us to share your case information   
with your immediate family? YES / NO

Please note that we do not accept any third party causes such as Work Cover or Motor Vehicle Accident Claims.

Signature Date\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_