PH: (02) 6282 2884
Suite 305 Woden Centre
WODEN ACT 2606
www.ghcchiro.com

GHC CHIROPRACTIC
NEW PATIENT FORM

First Name: ________________ Last Name: _______________________ Preferred Name: ________________

Address: ____________________________________ City: ____________________________State: _________

Postcode: ___________ Height: ________________ Weight: _______________

Email Address: ____

Telephone# (Mobile): ___________________ (H) ___________________ (W) __________________________

Occupation: ___________________________ Date of Birth: ____

Emergency Contact: ________________________________Phone: ___________________________________

Who Referred or Recommended you to this Office: ____

____

HEALTH CONCERNS

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

What makes it worse? ____

What makes it better? Does anything help? ____

Have you seen a Chiropractor before? Who? ______________________________When? ____________

How effective was the Chiropractic Care? ____

Who else have you seen about this? ____

Who is your Medical Doctor and when did you see them? _______________________________________

List any medical conditions that you have:

____

This office is a wellness chiropractic office. We will examine you for nerve interference. This is called a SUBLUXATION. A Subluxation can be caused by three types of stress; Physical, Biochemical, Mental and Emotional Stress.

Please give details of areas of stress in your life.

Physical (Past accidents/Falls,etc): ____

Biochemical (Medication, Smoking, Poor Diet): ____

Mental and Emotional (Work/Family, etc): ____

Anything else you want us to be aware of? ____

SYSTEMS REVIEW

Please Circle **Yes** or **NO** to the following questions about your general health. This information will give us a more complete understanding about your body's overall function.

Headaches	Y	N	Neck pain	Y	N
Dizziness	Y	N	Neck stiffness	Y	N
Blurred Vision	Y	N	Mid back pain	Y	N
Ringing / buzzing in ears	Y	N	Chest pain	Y	N
Difficulty swallowing	Y	N	Palpitations	Y	N
Loss of consciousness	Y	N	High blood pressure	Y	N
Numbness in any body part	Y	N	Low blood pressure	Y	N
Weakness in any body part	Y	N	Heart trouble	Y	N
Stroke	Y	N	Difficulty breathing	Y	N
Depression	Y	N	Low back pain	Y	N
Nervousness	Y	N	Stomach trouble	Y	N

Sleeping problems	Y	N	Indigestion	Y	N
Energy loss	Y	N	Liver problems	Y	N
Morning tiredness	Y	N	Colon problems	Y	N
Feeling faint	Y	N	Diabetes	Y	N
Sinus problems	Y	N	Kidney / bladder problems	Y	N
Allergies	Y	N	Poor circulation	Y	N
Female / Male Health Issues	Y	N	Upper limb problems	Y	N

Other: ____

Relevant Family History: ____

Please note any and all information, written or otherwise that you provide, is strictly confidential. No information or records will be released to any person, health fund, insurance company or any doctor without your written permission.

Cancellations*: We ask that you respect our cancellation policy to ensure we have enough time to contact other patients on our waiting list. 24 hours notice is required for cancellation or re- scheduling. If notice is not received, a non-attendance fee may be charged.*

Patients Signature: ____ Date: / /