

Date:



New Patient Registration Form

Please complete in **BLOCK CAPITALS**. All information will remain strictly **CONFIDENTIAL**.

| | | | |
|------------------------|--|------------------------|------------------------------|
| Name | Title: | Address | Address: |
| | First name: | | Town: |
| | Middle name(s): | | County: |
| | Last name: | | Postcode: |
| Further details | Gender: Female Male (please circle) | Contact details | Home phone: |
| | D.O.B: / / Age: | | Work phone: |
| | Occupation: | | Mobile: |
| | Marital status: | | Email: |
| | No. and age of children: | | Emergency contact: |
| GP (Doctor) | GP name: | | Where did you hear about us? |
| | Surgery name: | | |
| | Address: | | |
| | Phone number: | | |
| | Current medication: | | |

Please describe your presenting complaint

Medical History – please tick if you currently have any of these symptoms or have had any in the past

| | | |
|--|---|--|
| <p>Head & Neck</p> <input type="checkbox"/> Headache <input type="checkbox"/> Thyroid disease/goitre <p>Eyes, Ears, Nose & Throat</p> <input type="checkbox"/> Ear infections <input type="checkbox"/> Dizziness <input type="checkbox"/> Hearing problems <input type="checkbox"/> Ringing or buzzing in the ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Wear glasses or contact lenses <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Eye Pain <p>Neurological</p> <input type="checkbox"/> Stroke <input type="checkbox"/> Convulsions/fits/seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Weakness/paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Clumsiness <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Epilepsy <p>Musculoskeletal</p> <input type="checkbox"/> Broken bones <input type="checkbox"/> Dislocated joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Hernia | <p>Respiratory (Lung)</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Asthma <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Blood clots in legs / in lungs <input type="checkbox"/> Tuberculosis <p>Digestive</p> <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Gallstones <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Blood in stool/black stool <p>Urinary</p> <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney disease/stones <input type="checkbox"/> Burning pain on urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty starting urination <input type="checkbox"/> Weak urine stream <input type="checkbox"/> Loss of urine/lack of control <p>Male Genital</p> <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Lumps/pain in testicles | <p>Female Genital</p> <input type="checkbox"/> Changes to menstrual period <input type="checkbox"/> Heavy bleeding <input type="checkbox"/> Very painful menstruation <input type="checkbox"/> Lumps in breast <input type="checkbox"/> Miscarriage <p>Cardiovascular (Heart)</p> <input type="checkbox"/> High/low blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Fainting/blackouts <input type="checkbox"/> Heart attack <input type="checkbox"/> Palpitations (awareness of heartbeat) <input type="checkbox"/> High cholesterol levels <p>General</p> <input type="checkbox"/> Cancer <input type="checkbox"/> Bleeding problems/disorders <input type="checkbox"/> Loss of appetite <input type="checkbox"/> HIV <input type="checkbox"/> Diabetes <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Anaemia <input type="checkbox"/> Fever/chills/night sweats <input type="checkbox"/> Loss of balance <input type="checkbox"/> Bruise easily <input type="checkbox"/> Rashes <p>Other:</p> |
|--|---|--|

New Patient Registration Form (cont.)

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| Family History – please tick if any of these conditions apply to your close blood relatives | |
|---|------------------|
| Condition | Who was affected |
| <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Heart conditions | |
| <input type="checkbox"/> Lung conditions | |
| <input type="checkbox"/> Other: | |

Current complaint – using the symbols below indicate on the drawings where the symptoms are

Symbols

- === Numbness
- OOO Tingling
- VVV Dull Pain
- /// Sharp Pain
- XXX Burning
- ### Stiffness

How severe is your pain today? Please put a vertical mark to indicate

No pain ----- Maximum pain

I confirm that the information given above is true to the best of my knowledge and belief. I understand that this is a full consultation by a chiropractor including history taking and a physical examination to allow a diagnosis to be formulated, to which I give consent. This is not consent to any treatment at this stage.

Signature

Print name

Date

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