New Patient Acupuncture Form

ADULT CONFIDENTIAL PATIENT CASE HISTORY

(PLEASE PRINT)

Name: ____ Date: _______________

Address: ____________________ Town/Suburb: _______________ Postcode: ________

Telephone – Home: ____________ Business: _____________ Mobile: _______________

Email address: ____

Date of Birth: _________________ Age: ____________ Sex: ☐ Male ☐ Female

Occupation: _____________________________ Exercise/Sports _____________________

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Divorced ☐ Widowed

Spouse's name: _____________________ No. and ages of children ____________________

How many of your immediate family members attend our clinic? ____________

Are you in a private health fund? Y / N Are you covered for Acupuncture? Y / N

Have you had acupuncture before? Y / N Have you taken Chinese herbs before? Y / N

How did you hear about our clinic?

Friend or acquaintance Name: ______________________

Family member Name: ______________________

Another health professional Name: ______________________

Other-Please explain ____

Main reason for treatment today: ____

____

How long have you had this condition? __________________ Is it getting Better/ Worse/ Same?

Does anything make it better?

____

Does anything make it worse?

____

Have you received treatment for this condition before? Details__________________________

MEDICAL HISTORY- this information will help us to deliver a safe and effective treatment plan

List any medication you take

____

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List any herbs or supplements you take ____

Do you have any allergies? ____

History of injuries, surgeries, illnesses ____

Describe your diet ____

List type and frequency of exercise ____

I smoke ____________ cigarettes per day I drink ______________________ alcoholic drinks per day
I drink _____________ coffees per day I drink ______________________ litres of water per day

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Please indicate if any of these apply to your current health:

Currently Pregnant	Y / N	Bleeding Disorder	Y / N	Skin Infection	Y / N
Trying to Conceive	Y / N	Pace Maker	Y / N	HIV/AIDS	Y / N
Seizures	Y / N	Hepatitis	Y / N	Cancer	Y / N

What are your short-term health goals?

____

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What are your long-term health goals?

____

____

Please Tick ✓ any of the following that are relevant for you.

Digestion and Elimination

- Abdominal bloating
- Nausea or vomiting
- Constipation
- Abdominal pain
- Loose stool/ Diarrhea
- Excessive Flatulence

Respiratory

- Asthma
- Coughing
- Chest congestion
- Tightness in chest
- Wheezing
- Shortness of breathe

Cardiovascular

- High blood pressure
- Low blood pressure
- Palpitations
- Cold hands or feet
- Excessive sweating
- Varicose veins
- Bruise easily

Skin

- Eczema/ dermatitis
- Psoriasis
- Acne
- Dry skin

Thirst and Urination

- Excessive thirst
- No desire to drink
- Frequent urination
- Painful urinating
- Incontinence

Male Reproduction

- Low libido
- Impotence
- Poor fertility

Female Reproduction

- Irregular period
- PMT
- Painful periods
- Heavy periods
- Low libido
- Poor fertility
- Menopausal symptoms

Head and Throat

- Headaches
- Dizziness
- Sore throat
- Swollen glands
- Ringing in the ear
- Hearing changes
- Vision changes
- Blurred vision
- Sinus or nasal congestion
- Allergies
- Hayfever

Musculoskeletal

- Muscle pain
- Joint pain
- Muscle cramping
- General stiffness
- Muscle weakness
- Osteoporosis
- Arthritis
- Nerve referral pain
- Pins and needles
- Tendonitis

General Health

- General fatigue
- Flu and colds easily
- Feels the heat easily
- Feels the cold easily
- Swelling or edema
- Weight gain easily
- Poor mental clarity

PRIVACY POLICY STATEMENT and PATIENT INFORMATION

In accordance with the new Privacy Act, all information relative to your case is held in total confidence.

However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Policies on Fees, Guarantees, Disclosed Information & Research:

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation. I will also discuss any consultation fees with a health practitioner or staff member at this clinic prior to the service being provided.

2) I appreciate that **positive results of any treatment** that I receive at NeuroBalance Chiropractic **is not guaranteed**.

By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

Patient Signature ______________________________ Date ______________