New Patient Form

Name: _____

Date of birth: Month: _____ Day: _____ Year: _____

Address: _____

Email: _____ Home Phone: _____

Occupation: _____ Work: _____ Cell: _____

How did you hear about us? _____

_____

History of Complaint:

_____

Current Medications including topical and herbal & dietary supplements and for what condition:

_____

(Please circle all that apply) Do you have difficulty with any of the following?

Headaches	Dizziness	Earaches	Ringing in ears	Sinus problems
Loss of smell/taste	Muscle & Joint Pain	Neck/Shoulder Pain	Back Pain (upper/mid/low)	TMJ/Jaw Pain
Swollen/Stiff Joint	Rheumatoid Arthritis	Osteoarthritis	Pins/needles in extremities	Cold Hands/Feet
Sensitive Skin/Rashes	Varicose Veins	Deep Vein Thrombosis	Eczema/Psoriasis	Chest pains
Heart disease	Hi/Lo Blood Pressure	Heart Palpitations	Poor Circulation	Stroke
Phlebitis	Poor Digestion/Indigestion	IBS	Constipation	Diarrhoea
Kidney/Bladder	Liver/Gallbladder	Chronic cough	Shortness of Breath	Asthma
Bronchitis/Emphysema	TB	Diabetes	Thyroid trouble	Cancer
HIV/AIDS	Hepatitis	Fatigue	Hormone Imbalance	Vision problems/Loss
Vertigo	Hearing loss	Sleep disorder	Memory loss	Anaemia

Other:

Women

Menstruation - Painful/Heavy/Light/Normal/Irregular/Absent/Pregnant

Number of Children:_____

Menopause - Pre/Active/Post

Breast Tissue - Swollen/Painful/Cystic/Abnormal sensation/Other

Allergies: _____

Previous Medical History - Incl. Trauma/Car Accidents: _____

Surgical History (type and date): _____

_____

Family Medical History: (cancer, diabetes, hi/lo Blood Pressure, Heart Disease, other:

_____

Social History: ☐ Tobacco ☐ Coffee ☐ Drugs ☐ Alcohol ☐ Other

Any Special considerations: ☐ pacemaker ☐ Rods, Pins, Wires ☐ Artificial joints/limbs ☐ Medication Patch

☐ other _____