DR. RODNEY K. SIMMER

Chiropractic Physician

New Patient Form

SECTION A - Personal Details

Title: Mr Mrs Miss Ms **Full Name:** _____ **Date of birth:** _____ **Gender:** F M

Home Address:_____

_____

Phone Numbers - home: _____ **mobile:** _____ **work:** _____ **ext:**_____

E-mail address: _____ **Occupation:** _____

How did you find out about us: (please circle): Friend/ patient Yellow Pages Saw your sign Newspaper Other

Who should we thank for recommending you to us:

_____

Name of your GP: _____ **GP Clinic** :

_____

Have you had previous Chiropractic Care: Yes No (If Yes who did you see and when was your last visit): _____

_____

_____

Please explain why you have come to see us today:

_____

_____

_____

_____

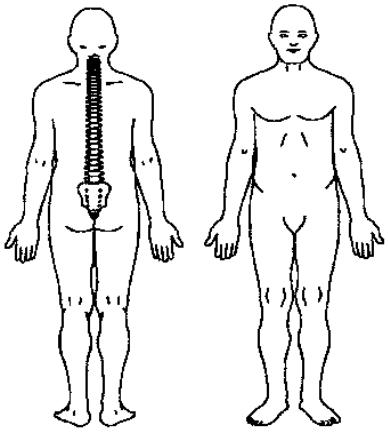
_____

SECTION B – Main Complaint/Problem

Where is your main complaint/ problem area:_____

_____

Please mark with a cross on the diagram the areas of your discomfort



When did you first notice the problem: _____

Why do you think the problem started: _____

Does anything help relieve it: _____

Does anything make it worse: _____

Has it been getting better, worse or staying the same:_____

Have you had this problem before: _____

Office Use

What type of pain is it: (e.g. burning, stabbing, aching) _____

Does the pain travel anywhere : (please circle) Yes No

If it does travel – where to: _____

Is it worse any time of the day or night: _____

Have you seen anyone else for this problem: (please circle) Yes No

If yes, please explain who you consulted and when: _____

_____

SECTION C – Current Health

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Rate your current health: (please circle below) 1 = terrible 10 = fantastic

1 2 3 4 5 6 7 8 9 10

What are your current health goals on a scale: 1 = most important 4 = least important

Pain relief _____ Increased Performance _____ Rehabilitation_____

Improve Health/quality of life _____ Other (please state)……

SECTION D – Illness History

Office Use

Other than your chief complaint do you have any other current health problems: _____

_____

Have you been treated for any health conditions in the last year – (If yes please explain)**:**

_____

_____

Have you ever had any operations – what for & when: _____

_____

Are you currently taking any medication:_____

_____

Have you ever had any serious accidents (car accidents, broken bones, falls) – what happened and when: _____

_____

Have you ever suffered from any major illnesses or conditions: _____

_____

Has any member of your family suffered from a serious disorder (such as diabetes, rheumatic conditions, cancer, heart conditions): _____

_____

Have you ever suffered from any of the following conditions: (please circle all that apply to you)

Dizziness	Fatigue	Headaches	Loss of sleep
Pain at Night	Unexplained weight loss	Numbness	Arthritis
Foot trouble	Low back pain	Sciatica	Swollen Joints
Asthma	Frequent Colds	Difficulty Breathing	High Blood pressure
Low Blood pressure	Chest Pain	Poor circulation	Anemia
Stroke	Pleurisy	Aids	Frequent Urination
Prostate trouble	Lumps in breast	Diabetes	Cancer

Signed: _____ Date: _____