

## CHIROPRACTIC NEW PATIENT FORM

Items with \* are mandatory as per Dubai Department of Health

Title\* Dr./Mr./Ms./Mrs      Name\* First \_\_\_\_\_ Last \_\_\_\_\_

Birthdate\*dd/m/yr \_\_\_\_\_ Age \_\_\_\_\_ Nationality\* \_\_\_\_\_ Sex/Gender\* \_\_\_\_\_

Mobile No.\* \_\_\_\_\_ Email\* \_\_\_\_\_

PO Box \_\_\_\_\_ Address \_\_\_\_\_

Insurance Co \_\_\_\_\_ Occupation \_\_\_\_\_ No. of children, if any \_\_\_\_\_

How did you learn about our centre? Please specify

- |  |   |
|--|---|
| <input type="checkbox"/> Dr. _____                   | <input type="checkbox"/> Websites _____           |
| <input type="checkbox"/> Patient _____               | <input type="checkbox"/> Facebook / Twitter _____ |
| <input type="checkbox"/> Magazine _____              | <input type="checkbox"/> Word of mouth _____      |
| <input type="checkbox"/> Other, please specify _____ |   |

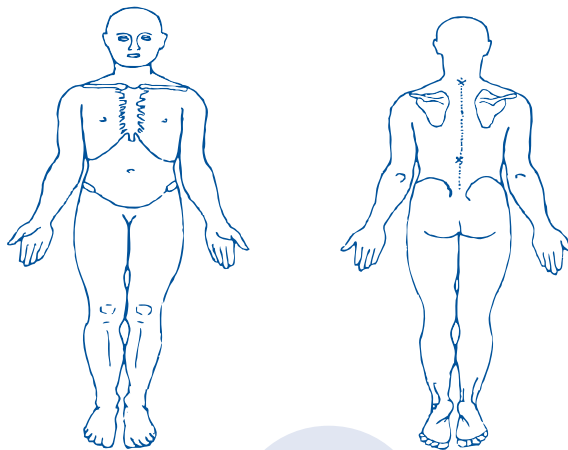
1. Which of the following is your reason for consultation ?      √ = Primary    X = Secondary

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Low Back Pain / Stiffness | <input type="checkbox"/> Shoulder Pain             | <input type="checkbox"/> General Arm Pain   |
| <input type="checkbox"/> Neck Pain / Stiffness     | <input type="checkbox"/> Elbow Pain                | <input type="checkbox"/> General Leg Pain   |
| <input type="checkbox"/> Mid-back pain / Stiffness | <input type="checkbox"/> Wrist / Hand Pain         | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Headache                  | <input type="checkbox"/> Pelvis / Hip / Groin Pain | <input type="checkbox"/> Sports Performance |
| <input type="checkbox"/> Numbness / Tingling       | <input type="checkbox"/> Knee Pain                 | <input type="checkbox"/> Pregnancy          |
| <input type="checkbox"/> Check up                  | <input type="checkbox"/> Ankle / Foot Pain         | <input type="checkbox"/> Other _____        |

Please draw in the area where your symptoms are

X = pain

0 = numbness / tingling



2. How long have you been experiencing your symptoms ? \_\_\_\_\_

3. How often do you experience your symptoms ? \_\_\_\_\_

4. On a scale of 1 (mild) to 10 (severe), how bad are your symptoms?

1      2      3      4      5      6      7      8      9      10

5. What makes your symptoms better? \_\_\_\_\_ worse? \_\_\_\_\_

**please turn over**

6. Have you had these symptoms before ? If so, when ? \_\_\_\_\_

7. Any other health changes in the last 3 months? \_\_\_\_\_

8. Have you seen any doctor about your complaint? Yes / No

Who \_\_\_\_\_ Treatment \_\_\_\_\_

9. Are you currently seeing another doctor for other reasons? Yes/ No

Who \_\_\_\_\_ Treatment \_\_\_\_\_

10. Have you ever been to a Chiropractor before? Yes / No

Who \_\_\_\_\_ When \_\_\_\_\_

11. Current Medication / Supplements \_\_\_\_\_

12. Which of the following diseases affect your immediate family?

- ( ) High Blood Pressure    ( ) Thyroid Problems    ( ) Arthritis    ( ) Joint Problems  
 ( ) Cancer    ( ) Heart Disease    ( ) Spinal Problems    ( ) Scoliosis  
 ( ) Diabetes    ( ) Lung Disease    ( ) Nerve Problems    ( ) Bone Problems  
 ( ) Other, relevant \_\_\_\_\_

13. List previous

a. Fractures / Dislocations / Injuries \_\_\_\_\_

b. Illnesses \_\_\_\_\_

c. Operations / Hospitalizations \_\_\_\_\_

d. X-rays and When \_\_\_\_\_

14. Social History:

a. Do you smoke? No \_\_\_\_\_ Yes, how many ? \_\_\_\_\_

b. Do you exercise? No \_\_\_\_\_ Yes, how often ? \_\_\_\_\_

d. Daily Fluid Water \_\_\_\_\_ Coffee/Tea \_\_\_\_\_ Alcohol / Cold drinks \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_