



# c1chiropractic

## new patient form

Telephone 9481 3911

Email contact@c1chiropractic.com.au

4/306 Station Street, Fairfield, 3078

Name	DOB
Address	Postcode
Occupation	Marital status
	Number of Children

Please underline the phone number most convenient to reach you on during work hours.

Home	Work
Mobile	Email

Please tick the box if you don't want to be contacted via SMS and E-mail

### Contacts

Emergency Name	Emergency Number
Medical Dr. Name	Clinic Name
Doctor's Number	Clinic Location

### Reason for your visit

What can we help you with today ? (The Doctor will discuss this with you in detail later)	
Have you been treated for this before? With whom, what sort of treatment? Did it help?	
For what reason you are trying a different practitioner?	
Have you had x rays or scans taken?	
How did you find out about the clinic?	

### Have you suffered any of the following? If yes, please explain

a) Accidents/falls/injuries/fractures/scares?	
b) Surgery (approx. Year and reason)	
c) Have you experienced dizziness, blackouts, double vision, fainting, ringing in your ears, or felt uncoordinated?	
d) Do you have pain that continues even when you keep still?	
e) Do you have any other health problems that you know of? eg. High blood pressure?	
d) Have you taken any medication? What for?	
e) (If female) Could you be pregnant?	
f) Do you have a family history of any diseases. EG. arthritis, cancer, stroke, tumors, aneurysms, heart problems?	

### Payment information

Do you have private health insurance with EXTRAS? If yes, list company.	
Do you have a healthcare/pension/student card? If yes list card number and expiry date	
Is this a TAC or workcover claim?	

Please tick the box if you do not wish to receive health information by mail/E-mail

Assessment will involve physical examination, which means having the doctor palpate (touch) you and may involve your partial undressing if clothing interferes with accurate evaluation, or technique. Tick box to give permission for this to occur

I agree that regardless of whoever pays for my account, I am ultimately responsible for the cost of my chiropractic care.  
(If the patient is under 18, I am/am not the legal guardian)

Signature of person responsible:	Date
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