Multicare Health

New Patient Entrance Form
79 Cecil Avenue Castle Hill
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It is important that all paperwork is properly filled out so that we can effectively serve you.
Failing to attend a booked, confirmed appointment or giving less than 48 hours notice for a cancellation of an appointment can result in a cancellation fee of $200.

VITAL STATS:

Surname:______________________________ Date:_____________________

Christian Names:_____________________________ __________________________

I prefer to be called "____________________"

Address:____

Suburb:_________________________________ Postcode:___________________________

Phone (Home):___________________________ Phone (Work):______________________

Mobile:_________________________________ Email:______________________________

Date of Birth:__________________________ Age:________________________________

Occupation:_____________________________ Hours worked/week:_________________

Employer:____

Private Health Insurance Carrier: ____
Membership Number: ____

Name of Medical Practitioner: _____________________Contact Number:_______________

Marital Status: _____________________________ Partner Name:___________________________
Children: ___________________________________

Most patients are referred to our office by a caring family member or friend, what is the name of the person who referred you? ____

Or: Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ Promotion ☐

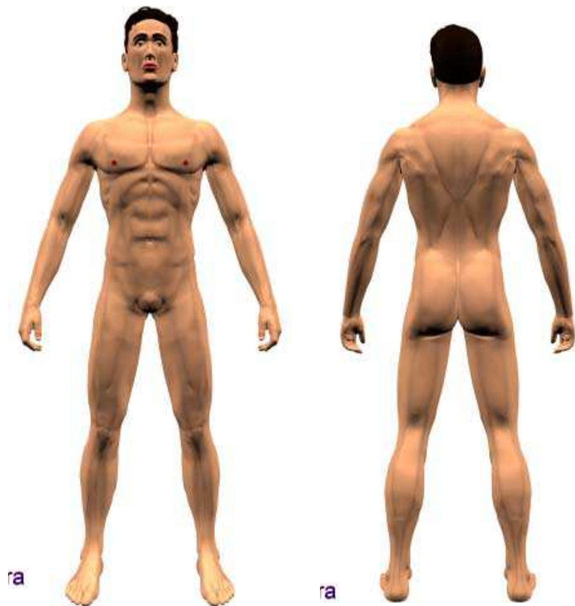
Chiropractic New Patient Information

List all accidents including car accidents, sporting injuries or falls resulting in an impact to your body ? Note date injury occurred, area of body impacted or injured and tests and/or treatment provided.

____
____
____
____
____

List all symptoms that you are experiencing in the table below.

Symptom	Date first noticed	What decreases this symptom	What increases this symptom



Severity of Pain

List region of pain and circle severity

number (1= least, 10= greatest)

Eg. _____Neck_________
1 2 3 4 5 6 7 8 9 10

MARK PAIN AREA

00 **Dull**

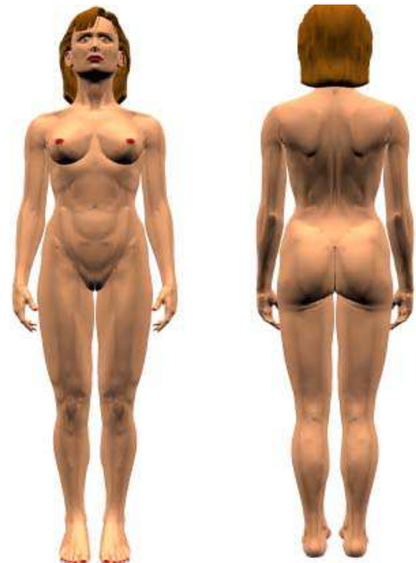
01 **I I I Sharp**

- - - Stabbing
+++ Burning
~~~ Tingling
***** Numbness**
□ □ □ **Throbbing**

1 ______________
1 2 3 4 5 6 7 8 9 10

_ ______________
1 2 3 4 5 6 7 8 9 10

3 ______________
1 2 3 4 5 6 7 8 9 10



For all symptoms listed have you CONSULTED OR had any TREATMENT for any of the symptoms listed above?
If yes for each of the symptoms reported write the date (if you can't remember estimate the year), the name of the practitioner,
Describe response (if any).

Date of initial consultation	Name of Practitioner	Treatment given	Response
e.g. Feb 2000	Dr Smith	Prescribed anti inflammatory medication	Some improvement at first now no change

Answer the following questions either yes or no and complete question if applicable

☐ Yes ☐ No Do you drink any alcoholic beverages? If Yes, How many? ____ alcoholic drinks per day ?
☐ Yes ☐ No Do you smoke ? If Yes, How many? ____ cigarettes per day
☐ Yes ☐ No Do you exercise regularly ? If Yes how often ____ times per week
☐ Yes ☐ No Have you had any orthodontic care or teeth extracted ? If Yes, When_______________
☐ Yes ☐ No Do you sleep well ? sleep posture ☐ side ☐ stomach ☐ back
☐ Yes ☐ No Do you wear any lift or support (orthotics) in your shoes ? If yes when were these prescribed ?_____________
☐ Yes ☐ No Is there any possibility that you may be pregnant at this time

Health problems may be the result of hereditary factors, or inherited spinal weaknesses. This information about your family members will provide a more complete picture of your health and improve the quality of your care.

Do you have a family history of diabetes ? ☐ Yes ☐ No
Do you have a family history of heart disease ? ☐ Yes ☐ No
Do you have a family history of cancer ? ☐ Yes ☐ No
Do you have a family history of scoliosis ? (curvature of the spine) ☐ Yes ☐ No

Please list all health problems or diseases in your family

Name	Relation	Past and present health problems

PLEASE MARK ON THE AREA OF THE BODY IN WHICH YOU ARE EXPERIENCING SYMPTOMS AND LIST THE SEVERITY OF PAIN using the code listed below.

- **Have you ever had an Operation or surgery or been taken to hospital for any reason ?** ☐ **Yes** ☐ **No**

If yes, list operation when it was performed and why it was performed.
List all special tests, pathology tests i.e. BLOOD TESTS and/or X-RAYS ?

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____
____
____
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List all medications, pills, prescription or non prescription drugs and/or supplements taken of any kind for any reason ?

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____
____
____

Please provide any other information you think may be relevant in the space below

____

____

DISCLAIMER AND RELEASE I hereby acknowledge and agree that the above information given is complete, true and correct. I understand that there may be a material risk associated with this and subsequent consultations and formally consent to all physical Examination, testing and/or treatment. You may be required to remove your clothes during your examination down to your underwear to perform some of the tests. I understand that this may be necessary to obtain clinical information and consent to this being performed as part of the examination procedure. It is an extremely rare complication of adjustments to the neck (less than one in two million that damage may occur to an artery in the neck that can result in stroke like symptoms. This has never occurred in this centre, however, we are still required to inform you and obtain your consent. If x-rays are to be taken, you agree that they will remain the property of Multicare Health for a minimum of 4 weeks to allow reporting and analysis. Copies may be obtained in digital format at a cost of $20. All payments are due at the time of your consultation when services rendered. I hereby agree to pay in full for all accounts rendered for services received at Multicare Health. In the event of an unpaid account I agree to pay all costs, including interest and legal fees associated with the collection of the debt.

SIGNED ………………………………………………………………….. DATE ………….. / …………….. / ……………