New England Chiropractic
(A.C.N. 137 440 825, ABN 11 749 118 066)
Dr. Janine M Kinahan

Personal Information

I appreciate the opportunity to serve you. Your responses are important to help better understand you, and deliver the best possible health outcomes.

Date_____

Last Name_____ First Name_____

Preferred Name_____ Birth Date ___/___/_____

If Under 18 parent/guardians names_____

Postal Address_____

City_____ State_____ Post Code_____

Home Phone_____Mobile_____ Work _____

Email address _____

Occupation_____

Emergency Contact Name _____Phone Number _____

Names and Ages of Children_____

_____

Referred By_____

Have you ever received Chiropractic Care ☐ YES ☐NO

If Yes, From Whom? _____ Date of last treatment? _____

Are you in a Health Fund? ☐YES ☐ NO Name of Health Fund_____

What is your Major Complaint today?_____

When did this symptom begin? _____

What do you think caused this complaint?_____

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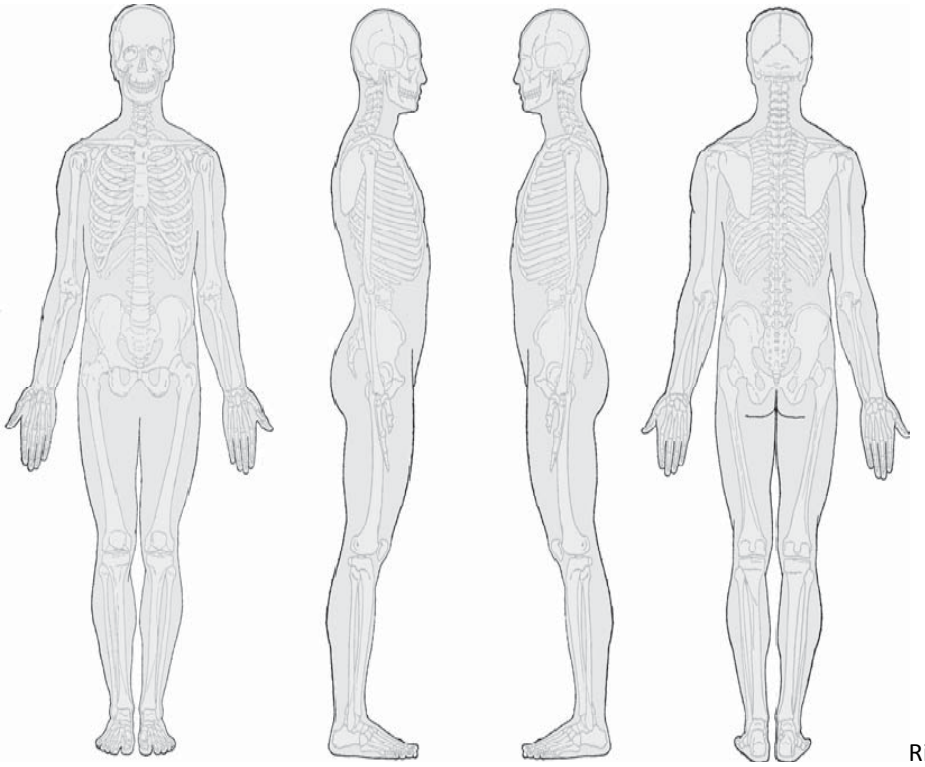
Please Mark on the picture below the areas where you are experiencing pain:

Front ***Right Side*** ***Left Side*** ***Back***

Right



Right

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain, use the key to the right and rate your severity of pain:

Right Now, what is the intensity of your pain?

0 .....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

What is the least intense this problem has been?

0 .....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

What is the most intense this problem has been?

0 .....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

0 = No Pain
1 = Minimal
2 = Very Mild
3 = Mild
4 = Mild to Moderate
5 = Moderate
6 = Moderate to Severe
7 = Moderately Severe, restricts some activity
8=Severe – limits most activity
9 = Very severe
10 = Excruciating

*Patient Name:*_____ *ID NUMBER*_____

Have you experienced these symptoms before? ☐ Yes ☐ No

If yes, when? _____

What makes this condition worse (e.g. heat,ice,lifting) _____

What makes this condition better (e.g. rest,

ice)_____

Have you been to another doctor about this condition? ☐ Yes ☐ No

Dr's Name_____ Date Consulted_____

Does this condition interfere with your sleep? ☐ Yes ☐ No

If yes, how many times does it wake you up at night? _____

What position do you sleep in? ☐ Front ☐ Back ☐ Side

Does it cause pain to cough, grunt or sneeze? ☐ Yes ☐ No

If yes, where? _____

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No

Does the pain radiate anywhere? ☐ Yes ☐ No If yes, where? _____

Do you have numbness or tingling in the legs? ☐ Yes ☐ No Explain_____

Is your blood pressure ☐ Normal ☐ Low ☐ High ☐ Don't Know

All Medications / Vitamins you are taking currently_____

_____

Have you ever had any hospitalization or surgeries? ☐ Yes ☐ No If yes, please list, with date

if possible_____

_____

What type of care are you looking for? ☐ Acute care (get rid of the pain)
☐ Maintance care (want to keep pain away)
☐ Wellness Care (want to have optimal health)

Additional Complaints

Please check all additional the complaints you have at this time, or have had in the past:

☐ Loss of Concentration	☐ Mid Back pain	☐ Fatigue	☐ Vision problems
☐ Eyes Sensitive to light	☐ Low Back pain	☐ Digestive trouble	☐ Dental appliances
☐ Memory Loss	☐ Right/Left shoulder pain	☐ Nausea	☐ Anemia
☐ Heavy feeling in head	☐ Right/Left arm pain	☐ Vomiting	☐ Heart Disease
☐ Dizziness	☐ Right/Left leg pain	☐ Diarrhoea	☐ Arthritis
☐ Ringing in Ears	☐ Pins and Needles in arms or legs	☐ Constipation	☐ AIDS/HIV
☐ Loss of Balance	☐ Sinus trouble	☐ Menstrual cramps	☐ Fractures (list)
☐ Loss of Smell	☐ Nervousness	☐ Heavy/light periods	_____
☐ Loss of Taste	☐ Chest Pain	☐ Jaw Pain	_____
☐ Pain Behind Eyes	☐ Shortness of Breath	☐ Cold hands/feet	_____
☐ Fainting/ Lightheaded	☐ Anxiety	☐ Diabetes	☐ Unusual weight loss
☐ Palpitations	☐ Depression	☐ Convulsions	☐ Loss of appetite
☐ Neck stiffness	☐ Insomnia	☐ Allergies (list)	☐ Headaches
☐ Upper back stiffness	☐ Hernia	_____	☐ Migraines
☐ Loss of Feeling	☐ Ulcer	_____	☐ Stroke
☐ Cancer	☐ Osteroporosis		

Do you have, or have you ever had, any diseases or medical problems not mentioned above?

☐ YES ☐ NO If so, Please list_____

_____

Is there any additional information you would like the doctor to know before beginning your care?

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____