Springfield Lakes
CHIROPRACTIC
&Massage

NUTRITION NEW PATIENT
Adult

Date: _________________

Personal Details

Title: _____ ____
Full Name

Address:____

____ Post Code:_________

Telephone: (Home) ____________________ (Mobile) _____________________

Email: ______________________________________ Date of Birth: ______________

No. of Children: ___ Partners Name: ____________ Occupation: __________________

I am happy to receive Reminders Via: SMS Email Both

Referral Details

Who can we thank for referring you to us:
Family/Friend (name): _________________________________

Social Media Google Signage Yellow Pages

Health Fund Health Care Practitioners Wellness Workshop Voucher

Health Details

Please tell us why you have come to the clinic today: ____________________________

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Have you had any major health issues in the past? Please summarise any information you wish to share: ____

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Do you Smoke? YES NO If yes, how many per day? _________

Have you ever smoked? YES NO If yes, when did you quit? _____________

Are you pregnant? YES NO If yes, when is you due date?_____________

Is this your first pregnancy? YES NO

Current Medical Conditions

Do you have any current medical conditions? If yes, please provide information including when diagnosed and by whom: ____

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Allergies/Intolerances:

Diary products	Medicines	Pollen
Soy products	Nuts	Pets
Wheat	Eggs	Other

If Other –Please specify: ____

Have these allergies been formally diagnosed? YES NO If so, when? __________

Current Medicines and Supplements (Please include over the counter medications and those prescribed by a medical or complimentary healthcare practitioner)

Name of Medicine	Dosage Per Day	Since When?	Reason for Taking?
Name of Supplement	**Dosage Per Day**	**Since When?**	**Reason for Taking?**

Is there anything else that you would like to include on this form? ______________________

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