GOLDSWORTHY WELLNESS

NEW PATIENT FORM

Personal Information:

☐ Ms. ☐ Mrs. ☐ Miss ☐ Mr. ☐ Dr.

Name (full with initials):______________________________

Date of Birth:______________________________

Address (including postal code): ______________________________

____

____

Phone (home):______________________________

Phone (work): ______________________________

e-mail:______________________________

Type of Injury

Is this injury a result of:

☐ Car Accident ☐ Work Injury ☐ Sports Injury ☐ Other

Previous Health Experience

Family Physician: ______________________________

Have you or are you currently seeing a:

- ☐ Chiropractor:______________________________
- ☐ Physiotherapist:______________________________
- ☐ Massage Therapist:______________________________
- ☐ Medical Specialist:______________________________

How did you find out about us?

☐ A Friend ☐ Drive By ☐ Your Doctor

☐ At a Sports Event ☐ Yellow Pages

☐ Other Practitioner

Health History

Please circle conditions you are experiencing, or have experienced.

Respiratory	Cardiovascular	Other
Chronic cough	High Blood Pressure	Loss of sensation
Shortness of Breath	Low Blood Pressure	Diabetes
Bronchitis	CCHF	(onset:___________)
Asthma	Heart Attack	Allergies
Emphysema	Phlebitis	Epilepsy
	Stroke/CVA	Cancer
	Pacemaker of similar device	Arthritis

Current Medications & Condition Treating:

Women: Pregnant? Yes □ (Number of Weeks:___________Due Date:_____________)No □

Painful Menstruation? Yes □ No □

Head/Neck: Vision Problems □ Hearing Loss □ Ear Problems □

Infections: Hepatitis □ Skin Conditions □ TB □ HIV □

Surgery: _________________________________**Date:**_____________________________

Injury:__________________________________ **Date:**_____________________________

Other Medical Conditions: (Digestive, Gynecological, Hemophilia, etc) __________

____

Of Special Note (Presence of internal pins, wire, artificial joints, equipment):_____

____

____

Soft Tissue/Joint Discomfort and its Nature

Low Back:____

Mid Back:____

Upper Back:____

Shoulders:____

Arms:____

Legs:____

Knees:____

Other:____