

New Patient Health Form

Confidential. All information is treated with the strictest privacy and confidentiality.
Type into this form and bring it to your first visit, or print and fill it in by hand.



About you

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname: First name:

Date of birth: Age: IC / passport (last 4 characters):

Gender: ☐ Male ☐ Female

Marital status (optional): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Languages spoken: ☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Cantonese ☐ Hokkien ☐ Japanese ☐ Others

Address:

Address (line 2): Postal code:

Email:

Mobile: Office: Home:

Occupation: Employer:

Spouse's name (optional): Contact number:

Children's names and ages (optional):

Who may we thank for referring you? Friend: Doctor:

How did you hear about us: ☐ Google search ☐ Our website ☐ Instagram ☐ Facebook ☐ TikTok ☐ Friend / family
☐ Corporate health talk ☐ Exhibition / event ☐ Brochure ☐ Others

Preferred clinic: ☐ Wisma Atria (Orchard) ☐ Novena

Experience with chiropractic

Have you been adjusted by a chiropractor before?

☐ No ☐ Yes, doctor's name:

Approximate date of last visit: Reason for the visit:

Has any child or adult in your family seen a chiropractor?

☐ No ☐ Yes, doctor's name:

Symptoms in the past 12 months

Tick any symptoms you have had in the past 12 months and add any details you can.

Cervical (Neck)

These nerves affect the head, ears and sinuses.

☐ Headaches / migraine

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? How long does it last?

Location: What makes it better / worse?

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

☐ **Dizziness**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

What makes it better / worse? _____

☐ **Ringing in ears**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

Which ear? _____

What makes it better / worse? _____

☐ **Recurrent flu / sinus**

How often? When? How long? _____

☐ **Neck: pain / stiff**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

Location: _____ What makes it better / worse? _____

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

☐ **Shoulder: pain / numb / tingling**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

Location: _____ What makes it better / worse? _____

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

☐ **Arm / elbow: pain / numb / tingling**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

Location: _____ What makes it better / worse? _____

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

☐ **Wrist / hands / fingers: pain / numb / tingling**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

Location: _____ What makes it better / worse? _____

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

Thoracic (Mid back)

☐ **Pain between shoulder blades**

How often: ☐ Everyday ☐ On & off ☐ Constant

When did it first start? _____ How long does it last? _____

Location: _____ What makes it better / worse? _____

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

☐ **Chest / ribs pain**

☐ Left ☐ Right ☐ Both

How often? _____

☐ **Breathing difficulty / asthma**

How long? When? Duration? _____

☐ **Digestive / gastric problems**

☐ Bloating ☐ Gas ☐ Indigestion ☐ Heartburn

Lumbar (Low back)

☐ **Low back: pain / ache**

How long? Comes and goes, or constant? _____

☐ **Hip pain**

☐ Left ☐ Right ☐ Both

How long? Comes and goes, or constant? _____

☐ **Legs / feet: pain / numb / tingling**

☐ Left ☐ Right ☐ Both

How long? Comes and goes, or constant? _____

☐ **Abdominal organs**

☐ Constipation ☐ Frequent urination

☐ **Fertility problems**

☐ **Knee / ankle / heel / foot (toes): pain / numb / tingling**

How often: ☐ Everyday ☐ On & off ☐ Constant

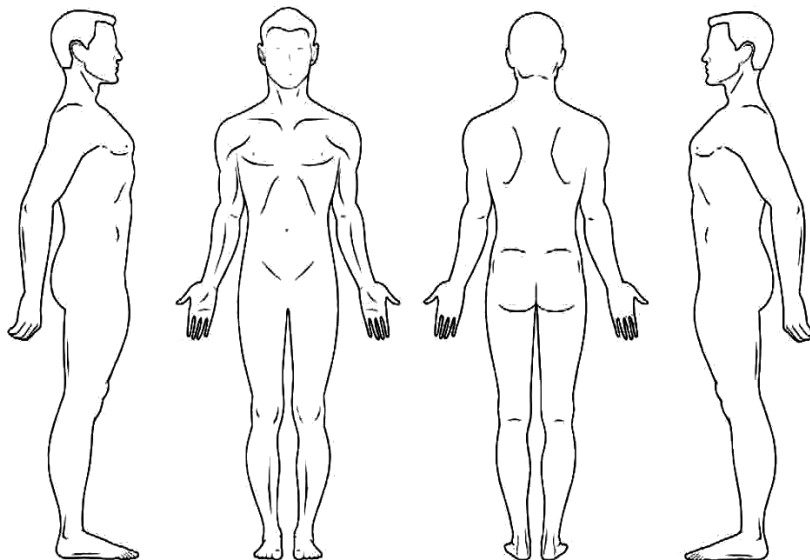
When did it first start? _____ How long does it last? _____

Location: _____ What makes it better / worse? _____

Type of pain: ☐ Sharp ☐ Numbness ☐ Dull ☐ Ache ☐ Burning

Where is your pain?

Circle or mark the area(s) of pain. If typing, describe them in the box below.



Describe the area(s) of pain:

Current medication

- ☐ Pain killers (incl. aspirin)
 ☐ Muscle relaxants
 ☐ Anti-inflammatory
 ☐ Anti-depressants
 ☐ Stimulants
 ☐ Blood thinners
☐ Insulin
 ☐ Tranquillisers
 ☐ Blood pressure medicine

Others:

Health conditions

Do you have any of the conditions below?

- ☐ Stroke / brain injury
 ☐ Diabetes
 ☐ Mental / emotional stress
 ☐ Heart attack / heart problem
 ☐ Kidney / urinary problem
☐ Gout
 ☐ High / low blood pressure
 ☐ Liver problem
 ☐ Arthritis
 ☐ Weight problem
 ☐ Cancer / tumour
☐ Rheumatoid arthritis

Allergies (type):

Women only

- | | | |
|-------------------------------------|-----------------------------|------------------------------|
| Are you pregnant? | ☐ No | ☐ Yes |
| Are you nursing an infant? | ☐ No | ☐ Yes |
| Do you have irregular cycles? | ☐ No | ☐ Yes |
| Are you taking birth control pills? | ☐ No | ☐ Yes |
| Do you experience painful periods? | ☐ No | ☐ Yes |

Injuries

Have you had any injuries or accidents at work? How long ago?

Have you had any sports injuries or accidents outside of work?

Any serious injuries at home, e.g. slips or falls?

Motor vehicle accidents? How long ago?

Do you recall any significant falls, accidents or injuries as a child / teenager?

Have you had any hospitalisations, operations or surgeries?

Broken bones / reconstructions?

Sports you play now:

Sports you played in the past:

Workplace

What is your present occupation? For how long?

What is your past occupation? For how long?

Nature of work and hours per day (tick):

- | | |
|--|--|
| ☐ Walking _____ hrs/day | ☐ Standing _____ hrs/day |
| ☐ Bending _____ hrs/day | ☐ Sitting at a computer _____ hrs/day |
| ☐ Lifting heavy objects _____ hrs/day | |

Lifestyle

- | | |
|--|------------------------------|
| ☐ Smoke | Packs per day / week: _____ |
| ☐ Drink alcohol | Drinks per day / week: _____ |
| ☐ Drink coffee | Cups per day: _____ |

How many hours do you spend at work per week?: _____

Do you exercise regularly: ☐ No ☐ Seldom ☐ Moderate ☐ Regularly

Type of exercise: _____

Consent to treatment / examination

I hereby give my consent to the doctors, associate doctors and assistants from Active Life Chiropractic to perform a thorough examination which includes a radiological exam, and administer appropriate and necessary chiropractic treatment and physiotherapy on / for me.

I consent to ActiveLife Chiropractic collecting, using and keeping the personal and health information on this form to assess and treat me, in line with Singapore's Personal Data Protection Act (PDPA).

Patient / guardian name: _____ Signature: _____ Date: _____

Thank you. Please bring this form to your first visit, or send it to your clinic before you come.