New Patient Application

Name_____ Age_____ D.O.B. (mm)_____ /(dd)_____ /(yy)_____

Street_____ Town_____ Postal_____

Home Phone_____ Work/Cell_____ Email_____

Occupation_____ Name of Spouse / Partner_____

If you were referred to our clinic, whom may we thank?_____

Please fill out the following information completely, regarding why you have come to our office:

What is your primary health concern/complaint? _____

How long have you been experiencing this problem?_____ How often is it occurring? _____

Please describe the type of symptom(s): ☐ Ache ☐ Electrical ☐ Burn ☐ Sharp ☐ Dull ☐ Other _____

Rate your level of discomfort: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

What seems to make it feel better? _____ Worse?_____

What other methods have you tried for this problem?

☐ Over the Counter Medication ☐ Prescription Medication ☐ Physical Therapy ☐ Surgery

☐ Massage Therapy ☐ Acupuncture ☐ Chiropractic ☐ Other: _____

Is there any additional information you would like to add regarding this problem? _____

_____

_____

Personal Health History

Please check if you have, or have had in the past, a problem in any of the following areas:

☐ Headaches	☐ Sleep Difficulties	☐ Eyes, Ears or Throat
☐ Neck Pain	☐ Sinus or Allergies	☐ Skin and Nails
☐ Upper Back Pain	☐ Asthma	☐ Reproductive/Urinary Tract
☐ Middle Back Pain	☐ Heart or Lungs	☐ Parkinson's or M.S.
☐ Lower Back Pain	☐ Liver and Gallbladder	☐ Stomach / Bowels / Digestion
☐ Hips/Buttocks	☐ Blood and/or Spleen	☐ Other: _____
☐ Shoulders	☐ Numbness/Tingling: Where? _____	

The accumulation of stress over time will result in poor health and will negatively affect your spine. Please list any physical, emotional or chemical stresses you have ever experienced:

Physical Stress (falls as a child, playing sports, prolonged postures or positions, car accidents etc):_____
_____
_____

Emotional Stress (family stress, financial worries, dislike your work environment etc.) _____
_____
_____

Chemical Stress (poor diet, smoking/alcohol, prescription and non-prescription drugs, sugar etc.) _____
_____
_____

Please list any medications: _____

Please list all surgeries: _____

Is there any family history of disease? ☐ No ☐ Yes If Yes: _____

Is there anything else you would like to add regarding your health? _____

_____

_____