NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:____________________________________Today's Date:________________

Address:____

City/State/Zip:____________________________ E-Mail:___________________

Phone: Home _______________ Work:_______________ Fax:_________________

Cell #:______________________________________ Marital status: M/W/D/S

Birthdate:____/____/____ Age:_____ Social Security #:_______________

Who may we thank for referring you? __________________________________

Your prior Doctor of Chiropractic:____________________________________

City, State: ____________________________________

Chiropractic adjusting techniques you've had success with:____________

Last time you went to previous Doctor of Chiropractic: ______________

General Practitioner name:____________________ Phone: ________________

City, State: ____________________________________

Please rate on a scale of 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP: ________________________

Other Specialists you are currently under care with:

Name: ____ Phone: ________________

Name: ____ Phone: ________________

Name: ____ Phone: ________________

Occupation:___________________________________

Employer name: ______________________________ Phone: _________________

Employer's address:____

Spouse's name:____________________________

Spouse's employer:__________________________

Children's names & ages:__________________

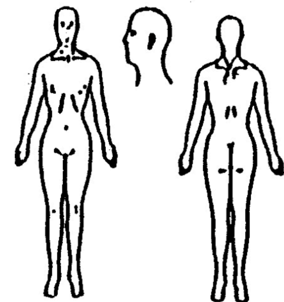
____

Favorite hobbies or interests:_____________

____

Method of payment for first visit:
_____Cash _____Check _____MAC _____Credit Card

Mark area(s) of Health Concerns



Health reasons for consulting our office:
1.________________________________ 2.______________________________

3.________________________________ 4.______________________________

Have you had same or similar problem(s) before?___Yes ___No
How long?: ______________ Please explain:
____

____

Father/Mother/Brother/Sister/Children, with similar problems?

____

Is this the result of an auto or work injury?______If so, when? __________

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.
____

Other doctors who have treated this problem:__________________________
____

Surgery you have had (ALL):____

Medication(s) you currently take:_____________________________________

Is there any chance you are pregnant? Yes_____ No______

What do you understand chiropractic care to be?
____

Do you know what a subluxation is? Yes or No If yes, please describe:
____

What daily rituals for spinal health do you presently practice?
____

Have you ever been diagnosed with cancer?___ If so, what type?
____

Do you have health (crisis care) insurance?______ Name of company:____________________

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:__________________________ Date:__/__/__