

NEW PATIENT APPLICATION

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

Patient Name _____ Today's Date _____

Birthdate _____ Age _____ Sex M / F E-Mail _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Work _____

Cell Carrier _____ Ok to receive text messages: yes no

Occupation _____ Your Employer _____

Employer's Address _____

Marital Status M/W/D/S/P Their Name _____ Their Employer _____

Children's Names & Ages _____

Prior Chiropractor _____ Last appointment _____

Address _____ Phone _____

General Practitioner _____

Address _____ Phone _____

May we send a report of your findings to this Practitioner? ___Yes ___ No

Favorite Hobbies or Interests _____

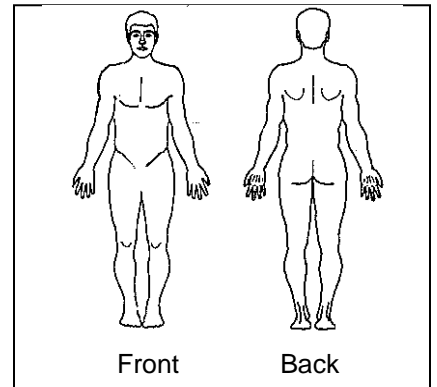
Who may we thank for referring you? _____

Health Reasons For Consulting Our Office:

1. _____ 3. _____

2. _____ 4. _____

Mark area of Health Concerns



Current Complaint (how you feel today): Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ___ 0-25% ___ 26-50% ___ 51-75% ___ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities?

(for example work, social activities, household chores) Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Have you had any X-rays, MRI, CT Scan for your area(s) of complaint? ___ Yes ___ No

Date Taken _____ What areas were taken? _____

Is this the result of an auto injury? ___ Yes ___ No work injury? ___ Yes ___ No

If so, when? _____

Other Doctors who have treated this problem _____

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

Please check all of the following that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks ___ |
| <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Abnormal Weight ___ Gain ___ Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy/Seizures |
- Tobacco Use – Type _____ Frequency _____ /Day
- Cancer/Tumor (Explain) _____
- Surgeries _____
- Medications _____
- Other Health Problems (Explain) _____
- None of the Above

What have you heard about chiropractic? _____

Do you know what a subluxation is? ___ Yes ___ No

If yes, please describe _____

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

Do you have health insurance? ___ Yes ___ No Insurance Plan _____

Method of Payment for First Visit: ___ Cash ___ Check ___ Credit Card

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: _____