

NEW PATIENT APPLICATION FOR CARE

Welcome to our practice! Please thoroughly complete all questions. All information is Confidential.

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: _____ # of Children: _____ SS#: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact : _____ Relationship: _____ Emergency Contact Phone: _____

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Do you have insurance? Yes or No **(If yes, please give the front desk your card to copy)** Are you the primary cardholder? Yes or No

Name of Insurance Company: _____

(If no), Name of primary cardholder _____ Date of Birth _____

Method of payment for first visit: Cash _____ Check _____ Credit Card _____

Health reasons for consulting our office: 1. _____ 2. _____
3. _____ 4. _____

Date of Onset? _____

What are you hoping Chiropractic care can do for you? _____

Have you had this condition before? _____ If yes, when? _____

Is this a result of an auto or work injury: _____ Date of Accident: _____ Have you lost days form work? _____

What other doctors have you seen for this condition? _____

What did they do? _____

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

When was your last visit to a Chiropractor? _____ Were you helped? _____

What Spinal Correction programs were you given? _____

Did you follow it? _____ If not, why? _____

How did the post X-Rays look? _____

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

Who is your General Practitioner? _____ Phone: _____

City, State: _____

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

I _____ hereby give permission to forward relevant information regarding my care to the above stated doctors

Signature: _____ Date : _____

What surgeries have you had? _____

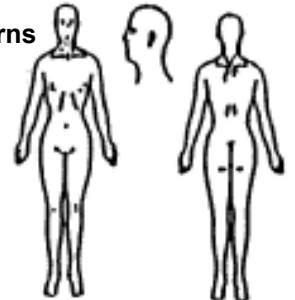
List medications you now take (prescription & non-prescription): _____

What are your favorite hobbies/interests? _____

Please mark X for present conditions, O for past conditions

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> 0-1 years ago | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Blurred Vision R L | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> 1-5 years ago | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Double Vision R L | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> More than 5 | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Upper Back Pain/Stiffness | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Other Accidents/Falls | <input type="checkbox"/> Mid Back Pain/Stiffness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer –Type_____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Headache | <input type="checkbox"/> Low Back Pain/Stiffness | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pain/Stiff Neck R L | <input type="checkbox"/> Numbness, Tingling or Pain | <input type="checkbox"/> Menopausal Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness/Tingling/Pain | in buttocks, thighs, legs, feet, toes | |
| <input type="checkbox"/> Swollen/Painful Joints | Arms/Hands/Fingers/Wrists R L | <input type="checkbox"/> Hearing Loss R L | |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Jaw Pain/TMJ R L | <input type="checkbox"/> Hip Pain R L | |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Head/Shoulders Feel Tired | <input type="checkbox"/> Foot Trouble R L | |
| <input type="checkbox"/> Pregnant (now) | <input type="checkbox"/> Difficulty in Excessive | <input type="checkbox"/> Chest Pain | |
| <input type="checkbox"/> Frequent Colds/Flu | (Standing, Walking, Bending, Riding, | <input type="checkbox"/> PMS / Menstrual Problems | |
| <input type="checkbox"/> Depressed | Twisting, Lifting, Household Duties) | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Shoulder Pain R L | <input type="checkbox"/> Difficulty Breathing | |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Ringing in Ears R L | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Allergies | |

Mark area(s) of Health Concerns



If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:

Parent/ Guardian's Name: _____

Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____ Phone: _____

Occupation: _____ Employer: _____ Work Phone: _____ SS#: _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy release

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

(Signature)

(Date)

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: ___/___/___