

**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 \_\_\_\_\_

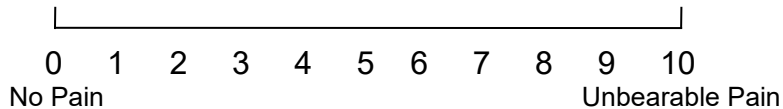
Who may we thank for referring you? \_\_\_\_\_

Health Reasons For Consulting Our Office:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Current Complaint (how you feel today): Please Circle

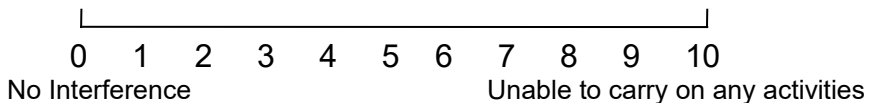


How often are your symptoms present?

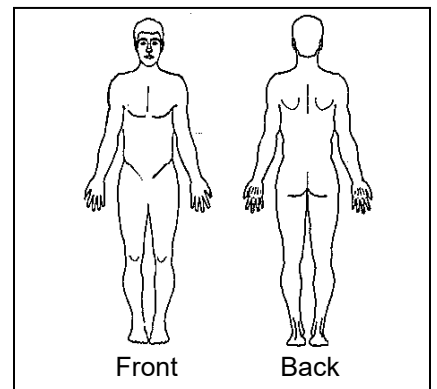
(Occasional) \_\_\_ 0-25% \_\_\_ 26-50% \_\_\_ 51-75% \_\_\_ 76-100% (Constant)

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

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



Mark area of Health Concerns



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: \_\_\_\_\_