NEW PATIENT APPLICATION

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

Name: ____ Today's Date: ________

Address: ____

City/State/Zip: _________________________________ E-Mail:__________________

Home Phone: ______________ Work:____________________ Fax:_________________

Cell #:____________________ Pager:___________________ Marital status: S/M/D/W

Birthdate: _________________ Age: __________ Social Security #:_______________

Who may we thank for referring you? _____________________________________

Your prior doctor of chiropractic and address: ___________________________________

Chiropractic techniques you've had success with: _________________________________

Last time you went to previous Doctor of Chiropractic: ____________________________

General Practitioner: ____________________________ City: ____________________

Your employer: ____________________________ Phone number:__________________

Employer's address: ____

Occupation: _____________________________________

Spouse's name: _____________________________________

Spouse's employer: _________________________________

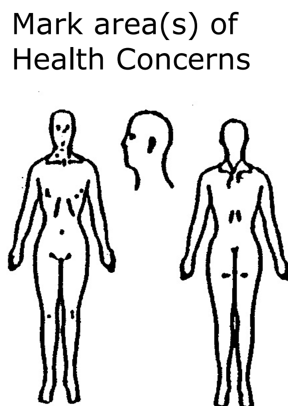
Children's names & ages: ____________________________

____

____

____

Mark area(s) of Health Concerns



Favorite hobbies or interests: ____

____

____

Method of payment for first visit: _____Cash ______Check ______Credit Card

Health reasons for consulting our office:

1. ______________________________________ 3. ________________________________

2. ______________________________________ 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: _______________________________________

____

Surgeries you have had: ____

____

Medication(s) you currently take: ____

____

Is there any chance you are pregnant? Yes No

What have you heard about chiropractic care? ______________________________________

____

Do you know what a subluxation is? If yes, please describe:___________________________

____

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

____

Have you ever been diagnosed with cancer? Yes No If so, what type? _____________

____

Do you have health insurance? Yes No 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:___________