

**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

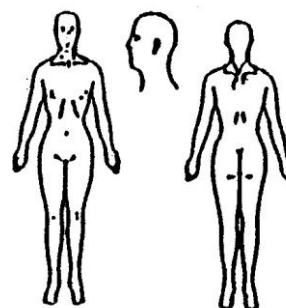
\_\_\_\_\_

Favorite hobbies or interests: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mark area(s) of Health Concerns



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: \_\_\_\_\_