

**NEW PATIENT APPLICATION**

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

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Fax: \_\_\_\_\_

Cell #: \_\_\_\_\_ Pager: \_\_\_\_\_ Marital status: M/W/D/S

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

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: \_\_\_\_\_ and City \_\_\_\_\_

Your employer: \_\_\_\_\_ Phone number: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Mark area(s) of Health Concerns

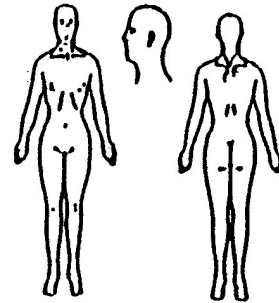
Spouse's name: \_\_\_\_\_

Spouse's employer: \_\_\_\_\_

Children's names & ages: \_\_\_\_\_

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

\_\_\_\_\_



Method of payment for first visit:

\_\_\_ Cash \_\_\_ Check \_\_\_ MAC \_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_

Surgery 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? \_\_\_ If so, what type?  
\_\_\_\_\_

Do you have health insurance? \_\_\_ 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: \_\_\_/\_\_\_/\_\_\_