# NEW PATIENT APPLICATION

Name: _____Date: _____

Mailing Address: _____

Email: _____ Phone: Cell: _____

Home: _____ Work: _____

Birth date: _____ Age: _____ Social Security #: _____

Marital status: M/W/D/S

How did you hear about us? _____

Your prior doctor of chiropractic and address: _____

Last visit to a chiropractor: _____

Chiropractic techniques you've had success with: _____

General practitioner: _____ City: _____

Occupation: _____ Employer: _____

Employer's address: _____

Mark area(s) of Health Concerns

Spouse's name: _____

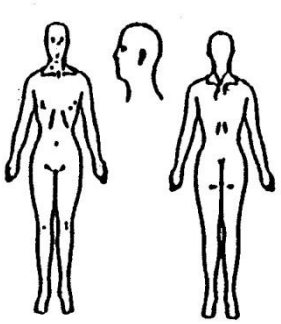
Spouse's employer: _____

Children's names & ages: _____

_____

Favorite hobbies or interests: _____

_____



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_____

Other doctors who have treated this problem: _____

_____

Surgeries you've 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: Y N

If so, what type? _____

**The above information is true and accurate to the best of my knowledge.**

**Patient or Guardian Signature _____**

**Today's Date _____**