NEW PATIENT APPLICATION

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

Name: ____ Date: ___________________

Address: ____

City/State/Zip: _______________________________ E-Mail: __________________________

Phone: Home _________________ Work: __________________ Cell #:__________________

Marital status: M/W/D/S Birth date: ____/____/____ 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: ____________________________ City ___________________________

Your employer: ___________________________ Phone number: ________________________

Employer's address: ____

Occupation: ____________________________________

Spouse's name: ________________________________

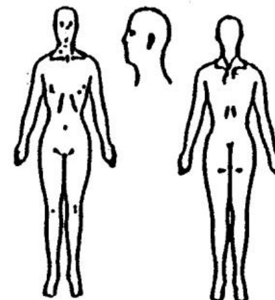
Spouse's employer: ____________________________

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 Savings Account

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 Workman'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.

Patient or Guardian Signature: ____
Date:_____/_____/_____