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 #:_____ Marital status: M/W/D/S

Birth date: ____/____/____ 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:_____ and City _____

Your employer: _____Phone number:_____

Employer's address:_____

Occupation:_____

Spouse's name:_____

Spouse's employer:_____

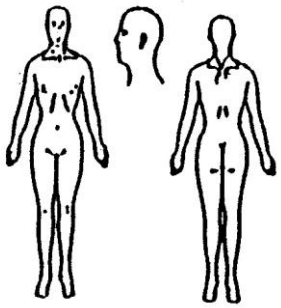
Children's names & ages:_____

Favorite hobbies or interests:_____

_____

Method of payment for first visit:
_____Cash _____Check _____MAC _____Credit Card

Mark area(s) of Health Concerns



Pain Scale
1 2 3 4 5 6 7 8 9 10
please circle

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:_____
_____

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:__/__/__