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: ___________________________

Cell #:___________________________ Marital status: M/W/D/S

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:____________________________ and City _____________________________

Your employer:________________________________Phone number:_________________________

Employer's address:____

Occupation:____

Spouse's name:____

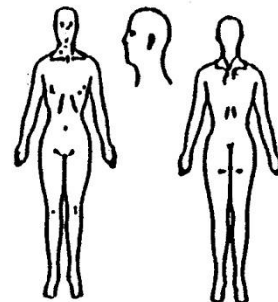
Spouse's employer:_______________________________________

Children's names & ages:___________________________________

Favorite hobbies or interests:_______________________________

____

Mark area(s) of
Health Concerns



If an exam is recommended, your method of payment for the exam:
_____Cash _____Check _____Credit Card

What type of care do you want, check all that apply:

- ☐ ***Chiropractic Care*** – To make sure that your spine and nervous system are in good repair for the ultimate healing.
- ☐ ***Enzyme Therapy*** – To nutritionally support your body to enhance this ultimate healing.
- ☐ ***Wellness Care*** – I want both types of care.

Health reasons for consulting our office:

1.______________________________ 2.______________________________

Is this condition getting progressively worse: ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily Routine Other ________________________

Have you had same or similar problem(s) before?___Yes ___No
How long has this condition been bothering you?:_____________ Please explain:__________________

____

Other doctors who have treated this problem:____

____

Father/Mother/Brother/Sister/Children, with similar problems?

____

Is this the result of an auto or work injury?______If so, when? __________________________________

Surgery you have had:____

Medication(s) you currently take:____

Supplement(s) you currently take:____

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? Yes No If yes, 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: _____/_____/_____