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:______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:__________________________

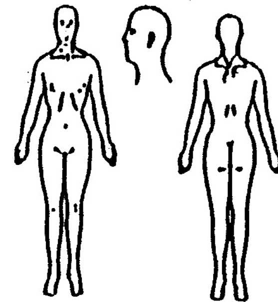
Spouse's employer:______________________

Children's names & ages:________________

Favorite hobbies or interests:_____________

____

Mark area(s) of Health Concerns



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:_______________

Name of subscriber______________________________ Date of birth______

Subscriber's SSN _ _ _- _ _ - _ _ _

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:__/__/__

Revised 7/1/09