New Patient Application

Please fill out form in its entirety

Today's Date ________________________ **Doctor: Rob Coombs, D.C.**

Name ______________________________ SS #____________________ Home Phone ____________________________

Address ____________________________ City ____________________ State ____________ Zip _________________

Email: ______________________________ Cell Phone ______________________ Preferred # to Call: Home / Work / Cell

Birth Date ____/____/_______ Age _______ Marital Status: M S W D How many children? ______________________

Children's Names and Ages: ____

Occupation __________________________ Employer ____

Employer's Address ____ Work Phone ___________________________

Favorite Hobbies or Interests: ____

Spouse's Name _______________________Occupation ________________ Employer _____________________________

Method of Payment for first visit: Cash_____ Check_____ Debit Card_____ Credit Card_____

Who may we thank for referring you? ____________________________________ Relationship:_________________________

Your prior Doctor of Chiropractic: ____Date of last visit: ______________________

Current Primary Medical Doctor ____ City: ______________________________

Is there any chance you are pregnant? ☐ Yes ☐ No

What goal would you like to achieve with your care in our office: ____________________________________

____

Health reasons for consulting our office	**Onset Date**	**Negative impact on lifestyle**
1.____________________________________ /	_______________	____________________________
2. ____________________________________ /	_______________	____________________________
3. ____________________________________ /	_______________	____________________________

What do you believe is the underlying cause of your symptoms? ____

Have you ever had the same or similar condition(s)? ❑Yes ❑No

If yes, when and describe:____

Days lost from work ____

Other Doctor's who have treated this problem: ____

What aggravates the problem? Sitting _____ Standing _____ Sleeping _____ Changing Positions ______ Activity _______

How would you describe it? Stabbing _____ Sharp _____ Burning _____ Aching______ Tingling ______ Numb ______

Does anything relieve it? ☐ Yes ☐ No

If yes, describe: ____

If no, what have you tried that has not helped? ____

Physical Stresses: (Check all that apply) ☐ Car Accidents ☐ Sports Injuries ☐ Slips/Falls ☐ Kicked by a Mule ☐ Other: _________

Have you had any broken bones or sprained any joints? ☐ Yes ☐ No (Please list: left / right & when injury happened)

____

What surgeries have you had? (Include dates): ____

Chemical Stresses: (Check all that apply) ☐ Environment ☐ Cigarettes ☐ Food ☐ Alcohol ☐ Medications ☐ Other_____________

What drugs are you taking and for how long? ____

____

Mental Stresses: (Check all that apply) ☐ Relationships ☐ Financial ☐ Work ☐ Other: ______________________________

What have you heard about Chiropractic care? ____

____

Do you know what a subluxation is? If yes, please describe ____

____

What are the healthiest habits you do in a week? ____

____

Have you ever been diagnosed with Cancer? ________ Heart Disease? ________ Other ______________________________

If yes, when? ____

Name of Insurance Company ____

Policy Holder's Name: ______________________________________ Policy Holder's DOB______/_________/____________

My reason for consultation with the Doctor is for evaluation of my physical health and potential for improvement. I understand that if the doctor believes I may benefit from Chiropractic care I will then proceed with the examination process. I understand, and am informed, that while extremely rare there are some risks to treatment including but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. It is important that our patients share our same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's innate intelligence or internal wisdom. Our specific method of correction is adjusting subluxations. We believe the greatest doctor is the one already inside each of our patients and we seek to help to maximize this inherent healing power without the use of drugs or surgery. Your signature verifies that the information given is complete and correct and that you accept, if eligible, chiropractic care on that basis.

____ ______________________________

Patient Signature *Date*