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: __________________ Cell: __________________ Work: __________________

Marital Status: M / W / D / S Height: ____________ Weight: _____________

Birthdate: ___/___/___ Age: _______ Social Security #: ______________________________

Whom may we thank for referring you? ____

Emergency Contact: _____________________________ Phone: _________________________

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: ________________________________

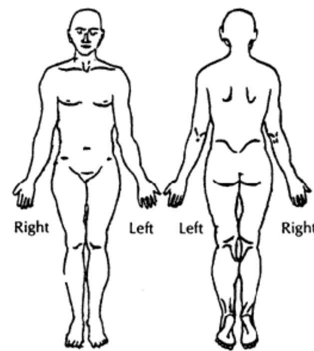
Spouse's Name: _____________________________

Spouse's Employer: __________________________

Children's Name & Ages: ______________________
____

Favorite Hobbies or Interests: __________________
____

Mark areas of Health Concerns



Health Reasons for Consulting Our Office:
1. ______________________________________ 3.______________________________________
2. ______________________________________ 4. ______________________________________

Have you had the 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: ____
____

Surgeries you have had: ____

Medication(s) you currently take: ____

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

What have you heard about chiropractic? ____
____

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 kind? _________________________
____

Do you have health insurance? _____ Name of Company: _________________________________
Name of Subscriber, DOB, SOC #____

Method of Payment for First Visit: _____ Cash _____ Check _____Credit Card

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's Signature ____ Date ____________________
Guardian or Spouse's Signature ____