NEW PATIENT APPLICATION

Welcome to our Practice! **Please thoroughly complete all questions**. Thank you.

Name: ________________________________ Todays Date: _______________________

Address: ____

City/State/Zip: __________________________E-Mail_____________________________

Phone: Cell# ____________________________Home:______________________________

Birth date: __/__/__ Age: ____ Social Security #: ______________ Marital status: M/W/D/S

Who may we thank for referring you? ____

Your prior doctor of chiropractic and address: _____________________________________

Last time you went to previous doctor of chiropractic: ______________________________

Chiropractic techniques you've had success with: __________________________________

General practitioner: ________________________ City: ___________________________

Your employer: _____________________________ Work number: ___________________

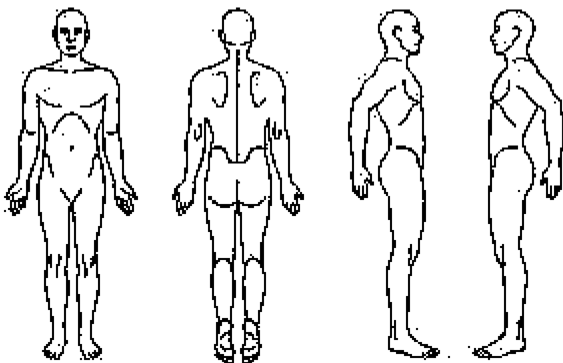
Employer's address: ____

Your occupation: _______________________ Spouse's name: ______________________

Children's names & ages: _________________ Favorite hobbies or interests: ____________

____

Mark areas of Concerns below:



Method of payment for first visit:

___Cash ___Check ___Credit Card

Pregnant _____Yes ____No

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 crash or work injury? _______ If so, when? ______________________

Other doctors who have treated this problem: ____

Surgery you have had: ____

Medication(s) you currently take: ____

Have you ever been diagnosed with cancer? _______ If so, what type? ______________________

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? _____________________________

____

Do you have health insurance? ____ Name of Insurance: ___________________________________

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: ___________________