

# New Patient Application

Welcome! ....We are honored you have chosen us to evaluate your condition.

Please thoroughly complete all questions so we may provide the highest standard of service for you. Thank you!

Full Name: _____			Nickname: _____			Today's Date: _____		
Address: _____								
City/State/Zip: _____			Email: _____					
Phone: Home _____			Work _____			Fax _____		
Cell #: _____			Pager _____			Marital Status: M/W/D/S		
Birth date: ____/____/____			Age: _____			Social Security #: _____		
Who may we thank for referring you? _____								

Your prior Doctor of Chiropractic: \_\_\_\_\_

and address: \_\_\_\_\_

Chiropractic techniques that you've had success with: \_\_\_\_\_

Last time you went to previous Doctor of Chiropractic: \_\_\_\_\_

General Practitioner: \_\_\_\_\_ City: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Children's Names & Ages: \_\_\_\_\_

In Case of Emergency, whom should we contact? \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Responsible Parties: Primary on your Insurance Card: \_\_\_\_\_

Date of Birth of Primary Insurance Card Holder: \_\_\_\_\_

Name of their Employer \_\_\_\_\_ City \_\_\_\_\_

Do you plan on using your health insurance? \_\_\_\_\_ Name of Company: \_\_\_\_\_

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Is it your wish to not only feel better, but also to correct the cause of your problem and create a long term

lifestyle of vibrant and extraordinary health?      Y      N

OR is pain relief your only concern?                      Y      N

(Please turn over and complete other side)

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Health Reasons for Consulting Our Office:

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

Have you had same or similar problems before? \_\_\_ Yes \_\_\_ No

If so, how long? \_\_\_\_\_

How do these affect your job, hobbies, sports, or relationships with those closest to you (strained emotional relationships, unable to support the family, etc.)? \_\_\_\_\_

**Health History:** (Please check box and explain further or answer N/A if it does not apply.)

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

Have you ever been diagnosed with cancer? \_\_\_ If so, what kind? \_\_\_\_\_

Have you ever been diagnosed with any other major illness or disease? If so, what was your diagnosis?

\_\_\_\_\_

Surgery you have had: \_\_\_\_\_

Medication(s) you currently take: \_\_\_\_\_

Yes, I have had injuries (car accidents, slips falls, sports injuries, etc)

\*Please describe these injuries on the "History of Traumas" form attached

\*Other doctors who have treated this problem:

Is there any chance that you are pregnant? Yes \_\_\_ No \_\_\_

What have you heard about Chiropractic? \_\_\_\_\_

Do you know what a subluxation is? Please circle: Yes / No If yes, please describe: \_\_\_\_\_

What daily rituals for spinal health do you presently practice?

**Patient Informed Consent**

I, (PRINT FULL NAME) \_\_\_\_\_, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff. I also attest that the above information is true and accurate to the best of my knowledge. My reasons for consultation with this office and their Doctors are for evaluation of my physical health and the potential for improvement.

**Patient Signature / Parent or Guardian Signature** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_