New Patient Application

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

Name: _____ Today's Date: _____

Preferred Name: _____ Birthdate: ____/____/____ Age: _____

Address: _____ Email: _____

City/State: _____ Zip: _____ Receive quarterly Newsletter: Yes / No

Phone: Home: _____ Work: _____ Cell: _____

Status: Married / Widow / Divorced / Single Social Security #: _____

Who may we thank for referring you? _____

Occupation: _____

Employers name: _____ Phone: _____

Spouse's name: _____ Phone: _____

Spouse's employer: _____ Phone: _____

Children's names & ages: _____

Emergency Contact: _____ Phone: _____ Other: _____

Favorite hobbies or interests: _____

Your Prior Doctor of Chiropractic: _____

City, State: _____ Approximate date of last Chiropractic treatment: _____

Chiropractic adjusting techniques you've had success with: __ _____

General Practitioner name: _____

Phone: _____ City_____ State: _____

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

_____

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Method of payment for first visit:

____ Cash ____ Check ____ Credit Card Person

Responsible for payment:

Name: _____

Phone Number: _____

Address: _____

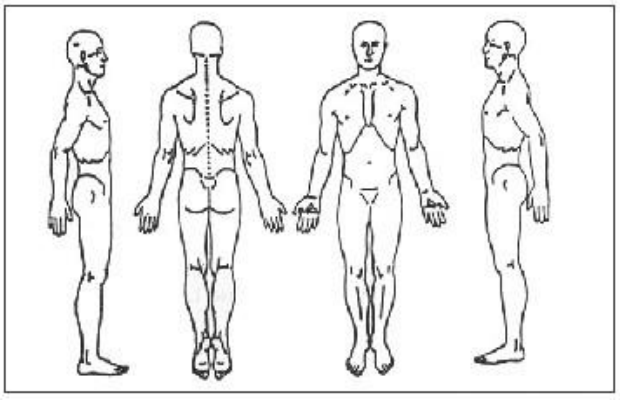
City: _____

State/Zip: _____

Do you have Health (crisis) Insurance? Y N

Insurance Company: _____

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1._____ 2. _____

3._____ 4. _____

Have you had same or similar problem(s) before? ___Yes ___No

How long? _____ Please explain: _____

_____

Does this condition interfere with your: Work _____Sleep ___ Daily routine_____
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

Insurances requires you to see in the first 90 Days?

If so, who? _____

Other doctors who have treated this problem: _____

What treatments did you receive: _____

Medication(s) you currently take: _____

_____

Do you take supplements? Yes or No If yes, please list_____

Is there any chance you are pregnant? Yes____ No ____

What do you understand chiropractic care to be? _____

Do you know what a subluxation is? Yes or No If yes, please describe:

_____

Do you play any sports or exercise regularly? Yes or No If yes please describe_____

_____

Do you smoke? Yes or No If yes how many cigarettes/packs a day? _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken Bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Carpal Tunnel ___Cancer ___Diabetes ___Emphysema ___Gout

___Heart Disease ___High Blood Pressure ___Kidney Disease ___Low Blood Pressure ___Migraines ___Numbness/tingling

___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid Disorder ___Tuberculosis ___Ulcers

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: __/__/_

Office: 717-942-2740 *Fax: 717-942-2752*