

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 _____ Work: _____ Fax: _____

Cell #: _____ Pager: _____ Marital status: M/W/D/S

Birthdate: ___/___/___ Age: _____ Social Security #: _____

Who may we thank for referring you? _____

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: _____

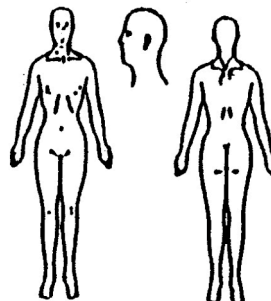
Children's names & ages: _____

Favorite hobbies or interests: _____

Method of payment for first visit:

____ Cash ____ Check ____ MAC ____ Credit Card

Mark area(s) of
Health Concerns



Health reasons for consulting our office:

1. _____ 3. _____
2. _____ 4. _____

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 or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

Other doctors who have treated this problem: _____

Surgery you have had: _____

Medication(s) you currently take: _____

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

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?

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

Do you have health insurance? ___ Name of company: _____

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: __/__/__