



Coastal Chiropractic New Patient Application

Please fill out form in its entirety

Today's Date _____

Name _____ SS# _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Preferred # to Call: Home / Cell

Birth Date _____ Marital Status: M S W D How many children? _____

Occupation _____ Employer _____

Employer's Address _____

Favorite Hobbies or Interests _____

Spouse's Name _____ Occupation _____ Employer _____

Method of Payment for first visit: Cash _____ Check _____ Debit Card _____ Credit Card _____

Who may we thank for referring you? _____ Relationship _____

Your prior Doctor or Chiropractor _____ Date of last visit _____

Current Primary Medical Doctor _____ City _____

Is there any chance you are pregnant? Yes No

What goal would you like to achieve with your care in our office: _____

Health reasons for consulting our office	Onset Date	Negative impact on lifestyle
1. _____	/ _____	_____
2. _____	/ _____	_____
3. _____	/ _____	_____

What do you believe is the underlying cause of your symptoms? _____

Have you ever had the same or similar condition(s)? Yes No

If yes, when and describe _____

Days lost from work _____ Other Doctor's who have treated this problem _____

What aggravates the problem? Sitting ___ Standing ___ Sleeping ___ Changing Positions ___ Activity ___

How would you describe it? Stabbing ___ Sharp ___ Burning ___ Aching ___ Tingling ___ Numb ___

Does anything relieve it? Yes No

If yes, describe _____

If no, what have you tried that has not helped? _____

Physical Stresses: (Check all that apply)

Car accident Sports Injuries Slips/Falls Kicked by a mule Other _____

Have you had any broken bones or sprained any joints? Yes No

Please list: left / right & when injury happened _____

What surgeries have you had? (Include dates) _____

Chemical Stresses: (Check all that apply)

Environment Cigarettes Food Alcohol Medications Other _____

What drugs are you taking and for how long? _____

Mental Stresses: (Check all that apply)

Relationships Financial Work Other _____

Biological Law dictates that your DNA requires these 5 "F.E.A.T.S." to be healthy. For each, circle which number most applies to you (1 = consistent 5 = Never)

Eat Food that grows

passionate Engagement

Activity that changes your pulse

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

positive Thoughts

Sleep or meditate

1 2 3 4 5

1 2 3 4 5

What have you heard about Chiropractic care? _____

Do you know what a subluxation is? If yes, please describe _____

What are the healthiest habits you do in a week? _____

Have you ever been diagnosed with Cancer? _____ Heart Disease? _____ Other _____

If yes, when? _____

Name of Primary Insurance Company _____

Name of Secondary Insurance Company _____

Policy Holder's Name _____ Policy Holder's DOB ____ / ____ / ____

My reason for consultation with the Doctor is for evaluation of my physical health and potential for improvement. I understand that if the doctor believes I may benefit from Chiropractic care I will then proceed with the examination process. I understand and, am informed, that while extremely rare there are some risks to treatment including but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. It is important that our patients share our same health objectives concerning chiropractic care. Regardless of what disease or condition is called, we do not offer to treat it. Our only practice is to eliminate a major interference to the expression of the body's innate intelligence. Our specific method of correction is adjusting subluxations. We believe the greatest doctor is the one already inside each of our patients and we seek to help maximize this inherent healing power without drugs or surgery. Your signature verifies that the information given is complete and correct and that you accept, if eligible, chiropractic care on that basis.

Patient Signature

Date