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)

☐ Enviornment ☐ 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 = consisntent .... 5 = Never)

Eat **F**ood that grows
1 2 3 4 5

passionate **E**ngagement
1 2 3 4 5

Activity that changes your pulse
1 2 3 4 5

positive **T**houghts
1 2 3 4 5

Sleep or meditate
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 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 imformed, 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 a disease or condition is called, we do not offer to treat it. Our only practice objective 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 to maximize this inherent healing power without the use of 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*