CONFIDENTIAL NEW PATIENT APPLICATION

PLEASE PRINT

Date:____________________

PERSONAL INFORMATION

Last Name:___________________________First:__________________________Middle:__________________
What name would you prefer to be called?____
Address:____City:______________State:________Zip:_________
Home Phone: ___________________Cell Phone:______________________E-mail:______________________
Social Security #:______________________Birthdate:________________Sex: M F [] Single [] Married
Business / Employer__________________________Position:____
Work Phone:___________________Emergency Contact:___________________Phone: __________________
Spouse's Name:______________________________Spouse's Occupation:________________________________
Children's Names and Ages:____
Favorite Hobbies or Interests:____

HEALTHCARE PROVIDERS AND REFERRAL

Whom may we thank for referring you? ____
Previous Doctor of Chiropractic: ____________________________How long under care? __________________
Family Doctor:____________________________________Phone: ______________________________________
Other Specialists you are currently under care with:
Name: ____Phone: ______________________________________
Name:____Phone: ______________________________________

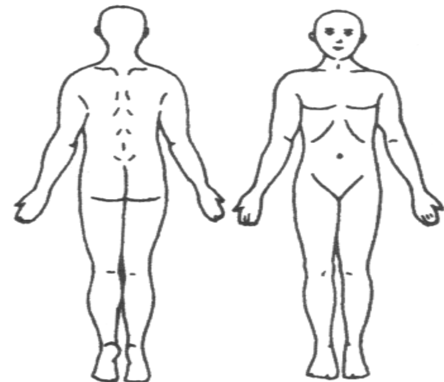
CURRENT HEALTH INFORMATION

What is the purpose of this appointment?____
When did this condition begin?____
Have you had similar problems before? []Yes []No If yes, for how long? ______________________________
Mother / Father / Brother / Sister / Children with similar problems? _________________________________
What doctors or therapists have you tried for this condition?_______________________________________
Please list all **prescription** medications, dosages and how long you have been taking:_____________________
____
Please list all **non-prescription** medications, dosages and how long you have been taking:__________________
____
Please list all **nutritional supplements**, dosages and how long you have been taking:______________________
____
What have you heard about Chiropractic care?
____
Do you know what a vertebral subluxation is? If yes, please explain:
____
What daily rituals for spinal health do you presently practice?
____

PLEASE MARK YOUR AREAS OF PAIN, DISCRIPTION AND INTENSITY USING THE FOLLOWING KEY:

*** =SHARP	~~~=DULL/ACHE
SSS = TIGHT	///=BURNING
NNN=NUMBNESS	::: =PINS/NEEDLES

MILD MODERATE SEVERE
1 2 3 4 5 6 7 8 9 10



Please indicate how many average hours per day you engage in the following activities:
____Hours Sitting ___Hours Driving ____ Hours at Computer ___Hours Standing ___Hours Lifting

Please indicate any traumas that you have **ever** suffered from:
[] Birth Trauma [] Slip / Fall [] Auto / Work Injury [] Sports Injuries [] Poor Posture

Which of these **continuous** traumas do you experience:
[] Sleep on Stomach / Side [] Extensive Computer Work [] Continuous Hours Sitting
[] Repetitive Lifting [] Carry Heavy Bag / Purse [] Driving Many Hours

Please indicate if you have received any of the following, when, what facility, and to which region of the body:
[]X-ray____
[]MRI / CT____
[]NCV/EMG ____
[]Bone Density / Bone Scan_________________________________

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST YEAR

MUSCULO-SKELETAL
[] Low Back Pain
[] Pain Between Shoulders
[] Neck Pain
[] Arm / Leg Pain
[] Joint Pain
[] Walking Problems
[] General Stiffness
[] Arthritis, location:________
[] Osteoperosis / Osteopenia

NERVOUS
[] Numbness / Tingling
[] Muscle Weakness
[] Concussion
[] Poor Balance
[] Cold/Tingling Sensations
[] Anxiety
[] Stress

GASTRO-INTESTINAL
[] Poor/Excessive Appetite
[] Excessive Thirst
[] Frequent Nausea
[] Vomiting
[] Constipation / Diarrhea
[] Liver / Gall Bladder Problems
[] Weight Problems
[] Abdominal Cramps
[] Gas/Bloating After Meals
[] Heartburn
[] Colitis / Crohn's Disease

GENITO-URINARY
[] Bladder Problems
[] Painful/Excessive Urination
[] Discolored Urine

CARDIOVASCULAR-RESPIRATORY
[] Short Breath
[] Blood Pressure Problems
[] Irregular Heartbeat
[] Heart Problems
[] Lung Problems/Congestion
[] Stroke / Aneurysm
[] Atherosclerosis / Arteriosclerosis

EYES-EARS-NOSE-THROAT
[] Vision Problems
[] Dental Problems
[] Sore Throat
[] Ear Aches
[] Hearing Difficulty
[] Frequent Congestion
[] Difficulty Chewing/Clicking Jaw

GENERAL
[] Eczema
[] Psoriasis
[] Allergies
[] Loss of Sleep
[] Headaches
[] Cancer, location:_________
[] OTHER:_______________
____
____

REPRODUCTIVE
[] Sexual Dysfunction
[] Prostate Problems

FEMALE ONLY
[] Menstrual Irregularity
[] Menstrual Cramping
[] Vaginal Pain/Infection
[] Breast Pain/Lumps
Any chance you are pregnant?
[]Yes []No []Not Sure

INSURANCE INFORMATION

Do you have health insurance: []Yes []No
If yes, what is the name of your health insurance company: ____________________________
If injured, was this an automobile accident, work injury or other type of injury: []Yes []No
If yes, what is the name of your AUTO or WORK insurance company: ______________________