

# NEW PATIENT APPLICATION

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

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Cell #: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Marital status: M/W/D/S

Who may we thank for referring you? \_\_\_\_\_

Prior Chiropractor \_\_\_\_\_ Last Appointment: \_\_\_\_\_

General Practitioner: \_\_\_\_\_

Your employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

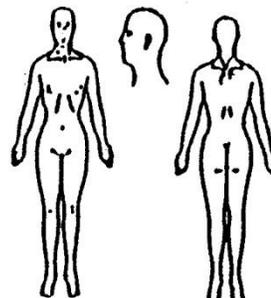
Spouse's name: \_\_\_\_\_

Children's names & ages: \_\_\_\_\_

Favorite hobbies or interests: \_\_\_\_\_

\_\_\_\_\_

Mark area(s) of  
Health Concerns



Check any boxes next to the social media platforms you saw our practice on:

Google  Facebook  Instagram  YouTube

Health reasons for consulting our office:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Is this condition getting progressively worse:  Yes  No  Constant  Comes and goes

Is this condition interfering with your:  Work  Sleep  Daily Routine Other \_\_\_\_\_

Have you had same or similar problem(s) before? \_\_\_ Yes \_\_\_ No

How long has this condition been bothering you?: \_\_\_\_\_ Please explain: \_\_\_\_\_

\_\_\_\_\_

Other doctors who have treated this problem: \_\_\_\_\_

Father/Mother/Brother/Sister/Children, with similar problems? \_\_\_\_\_

Is this the result of an auto or work injury? \_\_\_\_\_ If so, when? \_\_\_\_\_

Check all that apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Autoimmune _____                                | <input type="checkbox"/> Prostate problems                 |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Menstrual problems                |
| <input type="checkbox"/> High blood pressure                             | <input type="checkbox"/> Urinary problems                  |
| <input type="checkbox"/> Stroke (date) _____                             | <input type="checkbox"/> Abnormal weight ___gain ___loss   |
| <input type="checkbox"/> Recent fever                                    | <input type="checkbox"/> Currently pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid use (cortisone, prednisone, etc) | <input type="checkbox"/> Visual disturbances               |
| <input type="checkbox"/> Birth control pill                              | <input type="checkbox"/> Epilepsy/seizures                 |
| <input type="checkbox"/> Osteoporosis                                    | <input type="checkbox"/> Dizziness/fainting                |
| <br>   |  |
| <input type="checkbox"/> Tobacco use – type _____ Frequency _____/day    |  |

Cancer/tumor (explain) \_\_\_\_\_

Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Supplements: \_\_\_\_\_

Other health issues: \_\_\_\_\_

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? \_\_\_\_\_

Do you have health insurance? Yes No If yes, name of company: \_\_\_\_\_

Method of payment for first visit:  
\_\_\_\_ Cash \_\_\_\_ Check \_\_\_\_ Credit Card

What type of care do you want, check all that apply:

- Chiropractic Care** – To balance your spine and nervous system so your body can heal.
- Enzyme Therapy** – To nutritionally support your body and organs to enhance your healing.
- Wellness Care** – I want both types of care.

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_