

New Patient Application



General Information

Today's Date ___/___/___

First Name _____ Last Name _____ MI _____ Age _____ Birth Date ___/___/___

Address _____ City _____

State _____ Zip Code _____

Home # () _____ Cell # () _____ Work # () _____ Ext. _____

E-Mail Address (Health Tips) _____

Occupation _____ Employer _____

Male Female # of Kids _____ Single Married Divorced Widowed

Name of Spouse/Partner _____ Names and ages of Kids _____

Main reason for consulting our office today? _____

Referred by _____

****Please check if you are here for any of the following:** _____ Car Accident _____ Work Injury _____ Other Injury

Your Health Profile

Why this form is important - As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a **lifetime** of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

Please check any of the following conditions you have had in the past or present.

| Past | Present | Past | Present | Past | Present | Past | Present |
|------|-----------------|------|------------------------------|------|----------------------|------|-----------------------|
| | Headaches | | Kidney Disorders | | Allergies | | Depression |
| | Neck Pain | | Bladder Infections | | Asthma | | Anxiety |
| | Back Pain | | Painful Urination | | Sinus Problems | | Dizziness |
| | Shoulder Pain | | Loss of Bladder Control | | Lupus Stroke | | Gall Bladder Disorder |
| | Hand Pain | | Dermatitis/Eczema | | Seizures | | Weight Loss/Gain |
| | Wrist Pain | | Liver Disorder | | Fainting | | Loss of Appetite |
| | Elbow/Arm Pain | | Frequent Urination | | Hepatitis General | | Fatigue |
| | Hip Pain | | Excessive Thirst | | Ulcer | | Diabetes |
| | Knee/ Leg Pain | | Incoordination | | Abdominal Pain | | Numbness |
| | Ankle/Foot Pain | | Visual Change | | Rheumatoid Arthritis | | High Blood Pressure |
| | Joint Pain | | HIV/AIDS | | Cancer | | Heart Attack |
| | Arthritis | | Alcohol /Drug Dependence | | Tumor | | Chest Pains |
| | Jaw Pain | | Other Health Problems: _____ | | | | |

Please list any **surgeries** you have had with approximate dates: _____

Please list any **allergies**: _____

Please list any **past accidents** & dates: _____

Prescription medications may cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal. What medications are you currently taking? _____

(Over Please)

HEALTH HABITS

No Yes If yes, how much?

Do you smoke? _____ packs/week

Do you drink alcohol? _____ drinks/week

Do you drink soda? _____ cans/week

Glasses of water drank per day: _____

Number of fruits/vegetables consumed per day: _____

Please list any supplements you are currently taking: _____

LIFESTYLE

Job Description (activity done at work): _____

Work Schedule: _____

What are your hobbies? _____

How regularly do you exercise?

() daily () _____x/week () occasionally () never

What kind of exercises do you do? _____

How many hours of sleep do you get on average? _____

Clarifying Your Health Objectives

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

Have you ever been to another doctor who put you on a Health Development Program? [] Yes [] No [] Not Sure

If yes: Doctor's Name _____ [] Medical Doctor [] Chiropractor [] Other

How long were you able to stay on the program? _____

What were your results? _____

Were the results permanent? [] Yes [] No [] Somewhat

Are you as healthy (or healthier) today as you were 5 years ago? [] Yes [] No [] Don't Know

If yes, what strategies have you used? _____

Please circle the current state of your health on a scale of 0-10. (10 having optimal health, 0 being death) **0 1 2 3 4 5 6 7 8 9 10**

Will you be as healthy (or healthier) as you are today, 5 years from now? [] Yes [] No [] Don't Know

If yes, what strategies will you implement to get there? _____

If no or don't know, what strategies could you implement to get there? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed _____ Date _____/_____/_____

For Office Use Only- New Practice Member Health Objectives

Temporary Relief Notes:

Corrective Care

Maintenance Care

Wellness Care