

New Patient Application

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

Name: _____ Today's Date: _____
Preferred Name: _____ Birthdate: ____/____/____ Age: _____
Address: _____ Email: _____
City/State/Zip: _____ Social Security #: _____
Phone: Home: _____ Work: _____ Cell: _____
Status: Married / Widow / Divorced / Committed Relationship
Who may we thank for referring you? _____
Occupation: _____
Employer's name: _____ Phone: _____
Spouse/Partner's name: _____ Phone: _____
Spouse/Partner's employer: _____ Phone: _____
Children's names & ages: _____
Emergency Contact: _____ Phone: _____ Other: _____
Favorite hobbies or interests: _____
Your Prior Doctor of Chiropractic: _____
City, State: _____ Approximate date of last Chiropractic treatment: _____
Chiropractic adjusting techniques you've had success with: _____
General Practitioner name: _____
Phone: _____ City, State: _____
Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

Other Specialists you are currently under care with:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Method of payment for first visit

____ Cash ____ Check ____ Credit Card

Person Responsible for payment:

Name: _____

Phone Number: _____

Address: _____

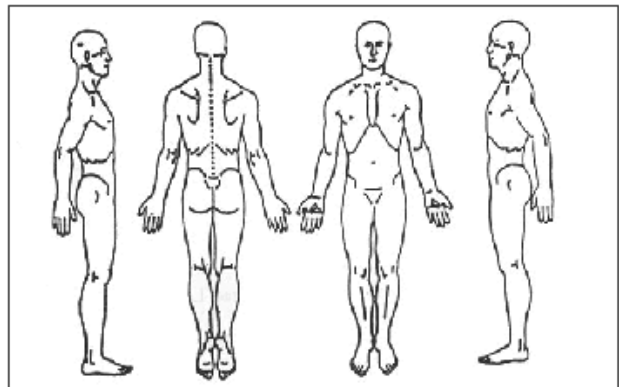
City: _____

State/Zip: _____

Do you have Health (crisis) Insurance? Y N

Insurance Company: _____

Mark Area(s) of Health Concerns:



Office: (757) 399-4700

Fax: (757) 399-0011

Health reasons for consulting our office:

1. _____ 2. _____
3. _____ 4. _____

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

How long? _____ Please explain: _____

Does this condition interfere with your: ___ work ___ sleep ___ daily routine _____
Father/Mother/Brother/Sister/Children, with similar problems?

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

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurances requires you to see in the first 90 Days? If so, who? _____

Other doctors who have treated this problem: _____

What treatments did you receive: _____

Medication(s) you currently take: _____

Do you take supplements? Yes or No If yes, please list _____

Is there any chance you are pregnant? Yes ___ No ___

What do you understand chiropractic care to be? _____

Do you know what a subluxation is? Yes or No If yes, please describe: _____

Do you play any sports or exercise regularly? Yes or No If yes please describe _____

Do you smoke? Yes or No If yes how many cigarettes/packs a day? _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken Bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___ Angina ___ Arthritis ___ Asthma ___ Allergies ___ Carpal Tunnel ___ Cancer ___ Diabetes ___ Emphysema ___ Gout ___ Heart
Disease ___ High Blood Pressure ___ Kidney Disease ___ Low Blood Pressure ___ Migraines ___ Numbness/tingling ___ Sciatica
___ Seizures ___ Sinus Problems ___ Spinal curvature ___ Stroke ___ Thyroid disorder ___ Tuberculosis ___ Ulcers

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: ___/___/___

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Patient Authorization regarding chiropractic care provided in an “education driven” environment

It is the practice of this office to provide chiropractic care in an “education driven” environment. Education driven adjusting involves a learning environment for a community of patients being cared for in a common adjusting room. Patients are within sight and hearing range of one another thus profoundly deepening the competency of how your ability to learn can enhance your recovery. A private or confidential setting is always available and accessible should such a less recovery centered and more exam or history driven exchange be necessary.

We provide the ability to protect you from “incidental disclosures” of health information by reminding you that if you wish to speak on private matters we may request a separate though less educationally productive and beneficial setting. Research has proven that the leading cause of death in the world is poorly made decisions. For this reason, even though it is more demanding upon the doctors and staff, we uphold the disciplines to function in this educationally driven setting so you can hear and learn from more exchanges and examples of ideal health care. In many instances, it is evident that doctors need to educate people may quite possibly be more important than caring for them if we are truly dedicated to making sustainable advances in healthcare.

Please grow your deliberateness at keeping your ears and eyes open and engaged with what every doctor and patient is asking and responding to. These actions will help you get well faster, stay well longer, stop perpetuating previous habits which may have been counterproductive to true health care and more.

Your signature indicates your understanding of this more deliberate and advanced approach to your appointments.

Name (Printed)

Signature

Date

Cancellation/No-Show Policy

It is the policy of this office that if you find it necessary to cancel or change an appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a \$55.00 cancellation fee.

Signature

Date