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
- ❑Corrective Care
- ❑Maintenance Care
- ❑Wellness Care

Notes: