HOLISTIC FAMILY
CHIROPRACTIC

Appointment Date and Time: _____ Account #: _____

NEW PATIENT APPLICATION FOR CARE

ALL AREAS ARE IMPORTANT. IF IT DOES NOT APPLY, JUST PUT A LINE THROUGH IT.

Name: _____ Pronounced: _____

Address: _____ Marital status: M / W / D / S

City: _____State: ____ Zip: _____ Family Appointment: Y / N

E-Mail: _____ Social #: _____

Phone: Home: _____ Work: _____ Cell: _____

Birth date: ____/____ /_____ Age: _____

How did you hear about or whom may we thank for referring you to us?_____

Your prior doctor of chiropractic name and location: _____

Last time you went to previous doctor of chiropractic: _____

General practitioner: _____ City: _____

Your employer: _____ Occupation: _____

Employer's address: _____

Spouse's name: _____ Spouse's employer: _____

Children's names and ages: _____

_____

Favorite hobbies or interests: _____

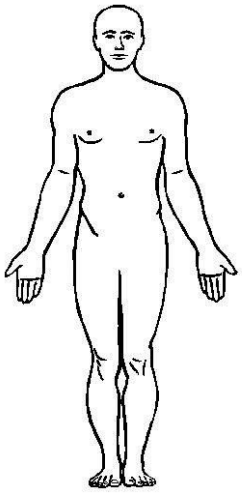
_____

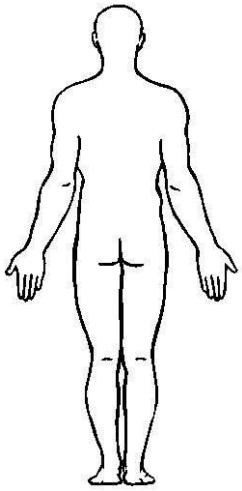
Health reasons for consulting our office:

1. _____ 3. _____

2. _____ 4. _____

Mark area(s) of Health Concerns On the Body Figures





What caused this current episode?

_____

_____

Date episode began: _____

Have you ever had similar problem(s) before? N / Y If so, for how long?

_____

Father/Mother/Brother/Sister/Children with similar problems: _____

Is this the result of an auto or work injury? N / Y If so, date of injury? _____

Other doctors who have treated this problem(s): _____

Surgeries you have had: _____

Medication(s) you currently take: _____

Supplement(s) you currently take: _____

Is there any chance you are pregnant? N / Y If so, how many weeks? _____

What do you know or what have you heard about chiropractic care?

_____

In your own words, what is a subluxation? _____

What daily rituals for spinal health do you presently practice?

_____

Have you ever been diagnosed with cancer? N / Y If so, what type and when?

_____

Do you have health insurance? N / Y If so, what company? _____

Who is the policy under? _____ Their date of birth _____

Circle the method of payment for this first visit: Cash Check Credit Card

By signing below, I am agreeing that 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 potential improvement.

Patient/Guardian Signature: _____ Date: _____