NEW PATIENT INFORMATION

Welcome to our office!

Please print legibly and answer *ALL* of the following questions completely.

Name:	Home Phone:
Address:	Work Phone:
City State ZIP	Cell Phone:
Birthdate: Age:	Email Address:
Occupation:	SSN:
Employer:	Hobbies:
Have you been to a chiropractor before? Y N	Marital Status: Married Single
If Yes, name of chiropractor:	Spouse's Name:
Do you have health insurance? Y N	Spouse's Employer:
If Yes, name of health insurance:	Children's Names and Ages:

MEDICAL HISTORY

Please check all that apply.

	Headaches		Neck Pain		Hip Pain		High Blood Pressure
	Fatigue		Thyroid Trouble		Elbow Pain		Low Blood Pressure
	Sinus Problems		Throat Problems		Wrist Pain		Anemia
	Fainting/Dizziness		Shoulder Tension		Ankle/Foot Pain		Stomach Problems
	Arthritis/Joint Pain		Chest Pain		Slipped Disc		Weight Trouble
	Loss of Smell		Shortness of Breath		Pinched Nerve		Depression
	Ringing in ears		Mid Back Pain		Diabetes		Sciatic Pain
	Menstrual irregularity		Tingling in legs/feet		Tingling in arms/hands		Pain btwn shoulder blades
	Memory loss		Lower Back Pain		Constipation		Other

Please share your reason for visiting us today:

_____

Are you here because of any accidents? Y N If yes, please explain. Will you be filing an accident claim? Y N

_____

WHO MAY WE THANK FOR REFERRING YOU? _____

FEMALE HISTORY

Are you pregnant? Y N If yes, how far along are you? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____