Chamberlain Chiropractic and wellness

New Patient Application

Welcome! .....We are honored you have chosen us to evaluate your condition.

Please thoroughly complete <u>all questions</u> so we may provide the highest standard of service for you. Thank you!

Full Name: _____Nickname:_____ Today's Date: _____

Address: _____

City/State/Zip: _____ Email: _____

Phone: Home_____ Work_____ Fax_____

Cell #: _____ Pager_____ Marital Status: M/W/D/S

Birth date: _____/____/_____ Age: _____ Social Security #: _____

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic: _____

and address: _____

Chiropractic techniques that you've had success with: _____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner: _____ City: _____

Your Employer: _____ Phone Number: _____

Employer Address: _____

Occupation: _____

Spouse's Name: _____ Spouse's Employer:

_____

Children's Names & Ages: _____

In Case of Emergency, whom should we contact? _____

Relationship: _____ Phone: _____

Do you plan on using your health insurance? _____ Name of Company: _____

Name of Responsible Parties: Primary on your Insurance Card: _____

Date of Birth of Primary Insurance Card Holder: _____

Name of their Employer _____ City _____

Is it your wish to not only feel better, but also to correct the cause of your problem and create a long term lifestyle of vibrant and extraordinary health? Y N

OR is pain relief your only concern? Y N

(Please turn over and complete other side)

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Health Reasons for Consulting Our Office:

1. _____ 3. _____

2. _____ 4. _____

Have you had same or similar problems before? ____Yes ____No

If so, how long? _____

How do these affect your job, hobbies, sports, or relationships with those closest to you (strained emotional relationships, unable to support the family, etc.)? _____

_____

Health History: (Please check box and explain further or answer N/A if it does not apply.)

❒ Father / Mother / Brother / Sister / Children, with similar problems?

❒ Have you ever been diagnosed with cancer? ____ If so, what kind? _____

Have you ever been diagnosed with any other major illness or disease? If so, what was your diagnosis?

_____

❒ Surgery you have had: _____

❒ Medication(s) you currently take: _____

❒ Yes, I have had injuries (car accidents, slips falls, sports injuries, etc)

*Please describe these injuries on the "History of Traumas" form attached

*Please list doctors who have treated this problem:_____

Is there any chance that you are pregnant? Yes ____ No ____

What have you heard about Chiropractic? _____

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

_____

What daily rituals for spinal health do you presently practice?

Patient Informed Consent

I, (PRINT FULL NAME)_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff. I also attest that the above information is true and accurate to the best of my knowledge. My reasons for consultation with this office and their Doctors are for evaluation of my physical health and the potential for improvement.

Patient Signature / Parent or Guardian Signature_____

Today's Date: _____