

New Patient Application

Welcome to **Chamberlain Chiropractic - An Integrated Process to Wellness!**

Please thoroughly complete all questions. Thank you!

Name: _____	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: _____

Favorite Hobbies & Interests: _____

Is it your wish to not only feel better, but 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

How long? _____

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

Health History:

- 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: _____
If you have had past injuries (car accidents, slips falls, sports injuries, etc) please check box below.
 Yes, I have had injuries. (Please describe these injuries on the "History of Traumas" form attached)

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

Other 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? If yes, please describe: _____

What daily rituals for spinal health do you presently practice?

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

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: _____