Chamberlain Chiropractic and wellness

New Patient Application

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

Please thoroughly complete all questions 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_______________ Cell #: __________________________________

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? Y / N 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 Symptoms affect your ability to :

Work effectively? ______________________________

Be at your best and present for your family and loved ones? ______________________

Enjoy your hobbies, sports, or doing the things you love to do? ____________________

If you were to have these problems resolved, how would your life change for the better?

____

____

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 ____

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: ______________