Adult New Patient Application

"A Healthy Spine Means a Healthier You!"

Name_____ Home Phone _____

Address_____ Work Phone _____

City, State, Zip_____ Cell Phone ____

E-mail Address _____

Birth date_____ Age_____ SS# _____

Occupation_____ Employer _____

Status: ❍Married ❍Widowed ❍Separated ❍Divorced ❍Single Spouse Name_____ No. of Children ____

To conserve resources we generally utilize email and text for regular communication. May we communicate with you via?

❍Email: ❍Text: ❍ Carrier (like AT&T, Etc.): _____

Most patients are referred to our office by a caring family member or friend. What made you to decide to visit our office?

❍Friend ❍Family Member Name: _____

❍Telephone Call ❍Yellow Pages Sign ❍website ❍presentation ❍Email

Please answer the following questions:

1. Spinal problems can cause a variety of health problems. Please check the health complaint(s) you are currently experiencing or experience on a periodic basis:

❍ Low Back Pain	❍ Arm or Hand Pain	❍ Carpal Tunnel Syndrome	❍ Indigestion
❍ Upper/Mid Back Pain	❍ Leg or Foot Pain	❍ Ear Infections	❍ Chronic Fatigue
❍ Neck Pain	❍ Asthma	❍ Frequent Colds	❍ Arthritis
❍ Shoulder Pain	❍ Allergies/Sinus	❍ Spinal Curvature	❍ Fibromyalgia

❍ Others _____

2. Please list your primary health concern you are experiencing:
   1._____ 2._____ 3._____
3. Auto and work injuries can cause serious spinal problems. Is this visit related to an auto or work injury? ❍ Yes ❍ No
4. Research shows that you spine should be checked regularly. When was your last complete Spinal examination including X-rays? ❍within the last year ❍ 1 - 5 years ❍ 5 years or longer ❍ Never
5. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
   ❍ YES ❍ NO If yes, circle one
6. Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? ❍ YES ❍ NO
7. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to twist, stretch or crack your neck, mid or lower spine? ❍ YES ❍ NO
8. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your posture?
   Poor - 1 2 3 4 5 6 7 8 9 10 - Very Good
9. Stress can cause or aggravate spinal problems. Please rate your stress levels over the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High
10. Are you currently taking prescription medication? ❍ YES ❍ NO If so, how many? _____
11. Spinal health is especially important during pregnancy. If female, is there any chance that you are pregnant?
    ❍ YES ❍ NO ❍ MAYBE If yes, when is your due date?_____ Or Date of Last Cycle? _____
12. Have you ever been diagnosed with cancer? ❍YES ❍NO If so, what kind?_____ Year diagnosed _____
13. Have you ever had spinal surgery? ❍ YES ❍ NO If yes, where?_____
14. If the doctor feels that you will benefit from chiropractic care, are you willing to follow his/her recommendations?
    ❍ YES ❍ NO
15. How will you be paying for today's visit? ❍ Credit/Debit Card ❍ Cash ❍ Check ❍ Other_____
16. Are you Medicare eligible? ❍ YES ❍ NO
17. What activities would you like to do that your health is impairing you to doing? _____
18. How would your life change if you have optimal health? _____
19. What needs to happen in order for you to have optimal health? _____

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

Signature:_____ Date _____

SYMPTOM SURVEY

Name _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip/Postal _____
E-mail Address _____ Cell Phone _____

1. Check off ALL of the following physical symptoms or health issues that apply:

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Hip Pain
- ☐ ☐ Sciatica
- ☐ Pain/Tension/Numbness
  - ___Shoulders ___Arms
  - ___Legs ___Hands
- ☐ Motor Vehicle Accident
- ☐ Disc Herniation
- ☐ Fibromyalgia
- ☐ Sports Injuries
- ☐ Headaches/Migraines
- ☐ Head Injury
- ☐ Arthritis

Which of the above bothers you the most? _____
How long have you been bothered by this condition? _____

2. Check off ALL of the following conditions you are experiencing or have experienced:

- ☐ High Blood Pressure
- ☐ Insomnia/Sleep Problems
- ☐ Fatigue
- ☐ Digestive Trouble
  - ☐ Constipation
  - ☐ Diarrhea ☐ Gas
  - ☐ Bloating ☐ Heart Burn
- ☐ Cancer
- ☐ Menopausal Symptoms
- ☐ PMS/Irritability
- ☐ Hormonal Imbalance
- ☐ Infertility
- ☐ Sexual Dysfunction
- ☐ Bladder Trouble
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Diabetes
- ☐ Dizziness
- ☐ Nervousness
- ☐ Stress/Anxiety
- ☐ Depression
- ☐ Heart Disease
- ☐ Ringing in Ears
- ☐ Sinus Problems/Allergies
- ☐ Weight Trouble
- ☐ Thyroid Disorder
- ☐ Other _____

Which of the above is your biggest concern? _____
How long have you been experiencing this condition? _____

2. Does this problem affect your ability to enjoy work?

- ☐ Yes
- ☐ No

3. Does this problem affect your ability to enjoy family and friends?

- ☐ Yes
- ☐ No

4. Does this problem affect your ability to sleep?

- ☐ Yes
- ☐ No

If you checked any of the above items, then you could be suffering from:

UNDETECTED NERVE DAMAGE — DESTRUCTIVE EFFECTS OF STRESS — AUTONOMIC IMBALANCE

There are several alternatives available to you. Please check the item most appropriate for you.

Signature: _____ Date: _____