NEW PATIENT APPLICATION

Today's Date:_____

Full Legal Name:_____ Age:_____ Gender: M / F

Address: _____ City, State, Zip: _____

Home Phone: ( ) _____Work Phone: ( ) _____ Cell Phone: ( ) _____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____ Marital Status: S M D W

Email Address: _____

Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Chief Complaint: _____

Is this related to an auto accident/work injury? O Yes O No If so, when: _____

Describe accident/ injury (if applicable):_____

_____

When did this condition begin? ____/____/____ Is this condition getting worse? O Yes O No

Is this condition: O Constant O Comes & goes O Activity related

Does complaint(s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? O Yes / O No Describe:_____

Have you experienced this condition before? O Yes / O No If so, explain: _____

Who have you seen for this and what treatments were tried? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? O Yes / O No Who? _____ When? _____

Reason for visit: _____

How did you respond? _____

Did your previous chiropractor take before and **after** x-rays? O Yes/ O No

Are you aware of any of your poor posture habits? O Yes / O No Explain: _____

Name: _____

Please check any of the following that you have experienced in the last 12 months

CERVICAL SPINE (NECK):

O Neck Pain
O Pain into your shoulders/arms/hands R/L
O Numbness/tingling in arms/hands R/L
O Hearing disturbances
O Weakness in grip
O Headaches/Migraines
O Dizziness
O Visual disturbances
O Coldness in hands R/L
O Thyroid conditions
O Sinusitis
O Allergies/hay fever
O Recurrent colds/flu
O Low Energy/Fatigue
O TMJ/Pain/Clicking

THORACIC SPINE (UPPER & MID BACK):

O Indigestion/Heartburn
O Heart Palpitations/ Murmurs
O Pain on Deep Inspiration/Expiration
O Shortness of Breath
O Heart Attacks/Angina
O Recurrent Lung Infections/Bronchitis
O Pain Into Your Ribs/Chest
O Tired/Irritable after eating or when you haven't eaten
O Hypoglycemia
O Reflux
O Asthma/Wheezing
O Ulcers/Gastritis
O Upper Back Pain
O Mid Back Pain
O Nausea

OFFICE USE ONLY

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

LUMBAR SPINE (LOW BACK):

O Low Back Pain
O Pain into your hips/legs/feet R/L
O Numbness/tingling in your legs/feet R/L
O Coldness in your legs/feet R/L
O Muscle cramps in your legs/feet R/L
O Constipation/Diarrhea
O Sexual dysfunction
O Recurrent bladder infections
O Frequent/difficulty urinating
O Menstrual irregularities/cramping
O Weakness/injuries in your hips/knees/ankles R/L

Other health conditions not mentioned: _____

_____

Current Medication Prescriptions:

Medication Name	Dose	Form	Route	Frequency	Date Started
E.G. Zyrtec	*10mg*	*Tablet*	*By Mouth*	*Once per day*	*10/24/2008*

Medication Allergies:

Medication Name	Reaction

Surgeries:

Type:	When:

HEALTH LIFESTYLE

Do you exercise? O Yes / O No What type? _____ How often? _____

What position do you sleep in? _____

Do you smoke? O Yes / O No How much/day? _____ O Former Smoker O Never Smoked

Do you drink alcohol? O Yes / O No How much/week?_____

Do you drink coffee? O Yes / O No How much/day? _____ Do you take supplements? O Yes / No

List **ALL** supplements:

_____

_____

IN CASE OF EMERGENCY

Name: _____

Relationship to Patient: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

Do you have health insurance that can be verified for participation? O Yes / O No

If yes, please bring your card to the front desk to be copied upon completion of paperwork.

The above information is true and accurate to the best of my knowledge. If applicable, I authorize the staff of Christian Chiropractic to verify my insurance benefits for chiropractic. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me (PATIENT). If this office chooses to bill any services to my insurance carrier, they are performing these services strictly as a service to me. Necessary reports and required information which aid in reimbursement will be provided; however my insurance company may deny my claims, and ultimately I am responsible for any unpaid balances.

Patient/Guardian Signature: _____ **Date:** _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We **DO NOT** offer to diagnose or treat any disease or condition other than **vertebral subluxation**. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do no offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's **objectives** pertaining to my care in this office have been answered to my complete satisfaction. I accept chiropractic as it is explained on this basis.

_____ _____
(signature) **(date)**

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to be evaluated and receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his associates have my permission to perform an x-ray evaluation. I have been advised the x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(signature) **(date)**