# NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State/Zip:_____ E-Mail:_____

Phone: Home _____ Work: _____ Cell #:_____

How would you prefer to receive appointment reminders? _____ Phone Call _____ Email _____ Text

Birthdate: _____/_____/_____ Age: _____ Marital status: M / W / P / D / S

Who may we thank for referring you? _____

Your prior doctor of chiropractic and address: _____

Chiropractic techniques you've had success with: _____

Last time you went to previous Doctor of Chiropractic_____

General Practitioner: _____ Phone _____

Address, City, State: _____

Please rate on a scale of 1 to 10 the quality of healthcare you feel you receive from your GP: _____

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Your employer: _____ Phone number:_____

Employer's address: _____

Occupation: _____

Spouse's name: _____

Spouse's employer: _____

Children's names & ages: _____

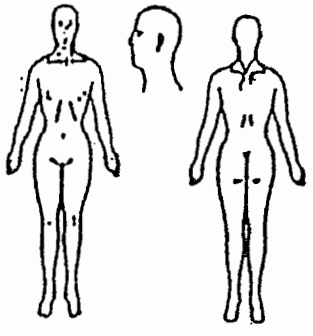
Favorite hobbies or interests: _____

Health reasons for consulting our office:

1._____ 3._____

2._____ 4._____

Mark area(s) of Health Concerns



Have you had same or similar problem(s) before? ___Yes ___No How long?: _____

Please explain:

_____

_____

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

_____

Is this the result of an auto or work injury? _____ If so, when? _____

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:_____

_____

Surgery you have had:_____

Medication(s) you currently take:_____

Is there any chance you are pregnant? Yes___ No___

What have you heard about chiropractic care?

_____

Do you know what a subluxation is? If yes, please describe

_____

What daily rituals for spinal health do you presently practice?

_____

Have you ever been diagnosed with cancer?___ If so, what type?

_____

Do you have health insurance?____ Name of company:_____

Name of Policy Holder _____ Relationship _____

Insured DOB_____

Method of payment for first visit: _____Cash _____Check _____MAC _____Credit Card

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:____/____/_____

Authorization of Release:
We at Cardonick Chiropractic firmly believe that open communication between all of your Doctors is vital to optimal care being rendered. Therefore, we respectfully request your permission to forward relevant information to the above stated Doctors.

Permission to forward relevant information regarding my care to the above stated doctors:

Patient's Signature: _____