

## Adult New Practice Member 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  Event: \_\_\_\_\_  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:
 

<input type="radio"/> Low Back Pain	<input type="radio"/> Arm or Hand Pain	<input type="radio"/> Carpal Tunnel Syndrome	<input type="radio"/> Indigestion
<input type="radio"/> Upper/Mid Back Pain	<input type="radio"/> Leg or Foot Pain	<input type="radio"/> Ear Infections	<input type="radio"/> Chronic Fatigue
<input type="radio"/> Neck Pain	<input type="radio"/> Asthma	<input type="radio"/> Frequent Colds	<input type="radio"/> Arthritis
<input type="radio"/> Shoulder Pain	<input type="radio"/> Allergies/Sinus	<input type="radio"/> Spinal Curvature	<input type="radio"/> Fibromyalgia
<input type="radio"/> 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 your 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 from 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. Copies of any X-rays and reports will be released upon written request, however original X-rays remain the property of the clinic.

Signature: \_\_\_\_\_ Date \_\_\_\_\_