NEW PATIENT APPLICATION

Welcome to Chubbuck Chiropractic! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date:_____

Address: _____

City/State/Zip: _____ Home Phone: _____

Cell #:_____ Carrier: _____ E-Mail: _____

Birth date: ____/____/____ Marital status: M/W/D/S Social Security #: _____

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: _____ City _____

Your employer: _____ Phone number: _____

Employer's address: _____

Occupation: _____

Spouse's name: _____

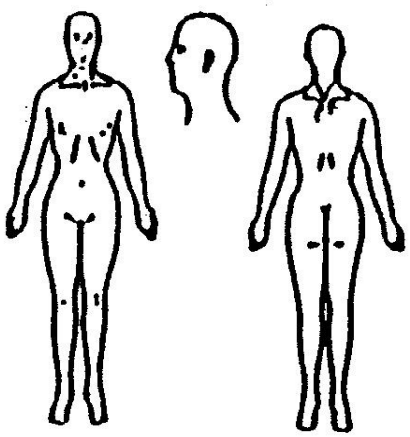
Spouse's employer: _____

Favorite hobbies or interests: _____

_____

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

Mark area(s) of Health Concerns



Health reasons for consulting our office:

1. _____ 3. _____

2. _____ 4. _____

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 Workman'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: _____

Other Traumas: _____

Surgeries you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes___ No___ Date of Last Menstrual Cycle _____

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?

_____

If you could have a perfect body, perfect health, what would you change in the next 5 years?

_____

What would you like your health to look like one year from now? Circle those that apply to you:

More Relaxed	More Alert	Improved Mood	Easier Standing	Easier Sitting	Improved Digestion
Better Memory	More Energy	Better Flexibility	More Coordinated	Better Balance	Improved Immunity
Stronger	More Rested	Easier Walking	Other		

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

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

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: _____/_____/_____