27 E Main St ▪ Versailles OH 45380 • 937-526-3737 • www.drbchiro.com

NEW PATIENT APPLICATION

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

Patient Name____ Today's Date_________________________

Address____

City/State/Zip_____________________________ Birthdate____________________ Age________________

Cell/Home Phone (____)_______________________ Work __________________________ Ext__________

Email Address______________________________________ Gender: ☐ Male ☐ Female

Occupation_______________________________ Your Employer___________________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Unemployed

Spouse's Name ______________________________Spouse's Employer_____________________________

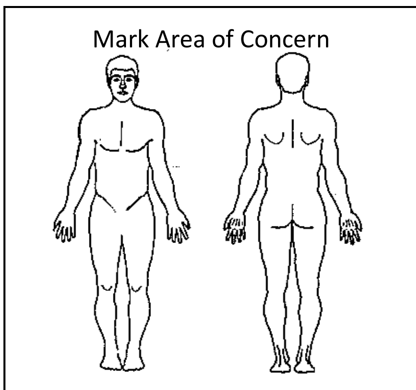
Children's Names & Ages ____

Prior Chiropractor_____________________________________ Last appointment__________________

General Practitioner___________________________________ City/State_______________________

Favorite Hobbies or Interests ____

Whom may we thank for referring you? ____



Health Reasons for Consulting Our Office:

1. ____________________________ 3. ____________________________

2. ____________________________ 4. ____________________________

Have you had similar problem(s) before? ☐ Yes ☐ No

Current Complaint (how you feel today): Please Circle

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

How often are your symptoms present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant) How Long? ___________

In the past week, how much has your pain interfered with your daily activities?
(for example work, social activities, household chores) Please Circle

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unable to Perform anything)

Is there any chance you are pregnant? ☐ Yes ☐ No

Have you had any (circle all that apply) X-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date Taken ____________________ What areas were taken? _______________________________

Is this the result of an auto injury? ☐ Yes ☐ No Work Injury? ☐ Yes ☐ No

If so, when? ____

Other Doctors who have treated this problem. ____

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

Please check all of the following that apply to you.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)__________
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Osteoporosis
___Prostate Problems
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___Epilepsy/Seizures
___Tobacco Use – Type_______________Frequency_______________/Day
___Cancer/Tumor (Explain)____
___Surgeries____
___Medications____
___Other Health Problems (Explain)____
___None of the Above

What have you heard about chiropractic? ____

Do you know what a subluxation is? ☐ Yes ☐ No

If yes, please describe. ____

What daily rituals for spinal health do you presently practice? ________________________________

Do you have health insurance? ☐ Yes ☐ No Insurance Plan: ____________________________________

Method of Payment for First Visit: ☐ Cash ☐ Check ☐ Credit Card

The above information is true and accurate to the best of knowledge. My reason for consultation with the doctor is for evaluation of the physical health and the potential for improvement.

Name: ____ Date: ___________________