



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 _____

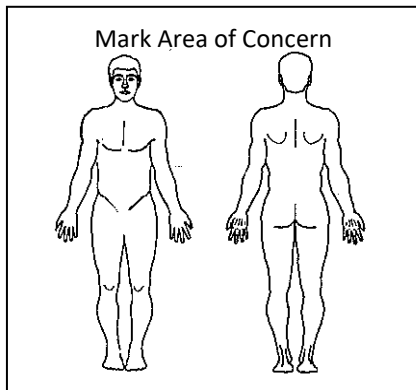
Children's Names & Ages _____

Emergency Contact _____ Relationship _____ Phone _____

Prior Chiropractor _____ Last appointment _____

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? _____

General Practitioner _____ City/State _____

Please check all of the following that apply to you.

<input type="checkbox"/> Alcohol/Drug Dependence	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Recent Fever	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Currently Pregnant, # Weeks _____
<input type="checkbox"/> Stroke (Date) _____	<input type="checkbox"/> Abnormal Weight ___ Gain ___ Loss
<input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.)	<input type="checkbox"/> Marked Morning Pain/Stiffness
<input type="checkbox"/> Taking Birth Control Pills	<input type="checkbox"/> Pain Unrelieved by Position or Rest
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Pain at Night
<input type="checkbox"/> Numbness in Groin/Buttocks	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Tobacco Use – Type _____ Frequency _____/Day	
<input type="checkbox"/> Cancer/Tumor (Explain) _____	
<input type="checkbox"/> Surgeries _____	
<input type="checkbox"/> Medications _____	
<input type="checkbox"/> Other Health Problems (Explain) _____	
<input type="checkbox"/> 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: _____