ASHVILLE CHIROPRACTIC & WELLNESS CENTER

NEW PATIENT APPLICATION FOR CARE

WELCOME to our practice! Please thoroughly complete all questions. Thank you!

Patient Name _____ Date _____

Address _____ City _____ State _____ Zip_____

Phone: Cell (____) _____ Home (____) _____ Work (_____) _____

Date of Birth _____/_____/_____ Age ____ Email address _____

Social Security Number _____ Marital Status: Married/Divorced/Single/Other _____

In Case of Emergency, contact:

Name _____ Relation _____ Phone (_____) _____

Who may we thank for referring you? _____

Occupation _____ Employer _____ Phone (_____) _____

Employers address _____

Spouse's name _____ Spouse's employer _____

Children's name & ages _____ _____ _____ _____

Favorite hobbies or interests _____

Your prior doctor of chiropractic _____ Office location _____

Last time you were checked by your prior doctor of chiropractic _____

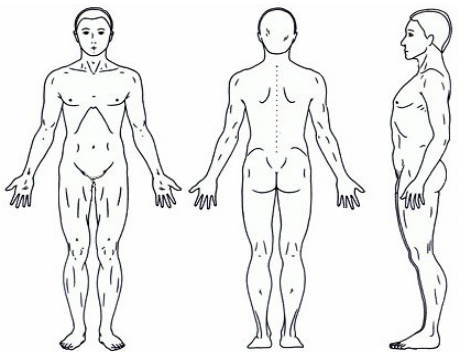
Techniques you've had success with (if known) _____

General practitioner _____ Office location _____

Method of payment for first visit: Cash Check Credit Card HSA

Do you have health insurance? YES / NO If yes, name of company _____

Mark area(s) of health concerns



Reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Have you had the same or similar problem(s) before? YES / NO

If yes, please explain ____

Do you have a family member with similar problems? ______________________________

Is this the result of an auto accident or a work injury? YES / NO If yes, when? ____________________

List any other doctors that have treated this problem:

____

____

Surgeries you have had: ____

Medication(s) you currently take: ____

Women: Is there any chance you are pregnant? YES / NO

Have you ever been diagnosed with cancer? YES / NO

If so, what type and when: ____

What have you heard about chiropractic care?

____

Do you know what a subluxation is? YES / NO

If yes, please describe:

____

What daily rituals for spinal health do you presently practice?

____

Any other concerns please describe here:

____

____

____

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.

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Patient or Guardian Signature: ______________________________ Date: _____/_____/_____

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