Adult New Practice Member Application

Fill out this questionnaire at your own convenience. Your answers are saved as you go, so you don't need to finish it all in one sitting. Contact us with any questions.

Submit the form only when you have answered all that you can.

1

Is this application for a minor under the age of 18?

○ Yes ○ No

2

CONFIDENTIAL PATIENT INFORMATION:

First Name: Last Name: Date of Birth: Gender: ○ M ○ F

Height (ft, in): Weight (lbs): Your Occupation:

Street Address: Apt./Unit#:

City: State: Zip Code:

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Name of Spouse:

# of Children: Name(s) of Children:

Cell Phone: Email: Preferred Method of Contact:

Other Phone: How did you hear about us?

3

Emergency Contact: Emergency Relation: Emergency Phone:

6

Who is your Primary Care Physician? Date of your last visit:

Reason for your last doctor visit:

7
What other healthcare providers are you currently seeking care from for this condition?

	Name	Specialty
1		
2		

CURRENT HEALTH CONDITIONS

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Our Doctors will recommend care for you based on 2 things...

1. The Doctors findings from your first visit

2. YOUR health goals

Please describe what your immediate, short-term, and long-term health goals are so our doctors can put the best plan in place for you.

1. What are your immediate health goals?

2. What are your short-term health goals?

3. What are your long-term health goals?

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What would you like to gain from chiropractic care?
○ Resolve existing challenge ○ Overall wellness ○ Both, reach my health goals and achieve overall wellness

10
Have you ever visited a chiropractor before?
○ Yes ○ No

If yes, which practice(s)?

When was your last visit?

How often did you receive care?
○ Every Week ○ Every Month ○ Only when it hurt

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What primary health concern brings you into our office?

When did this condition first begin?

How did this problem start?

Is this condition:

How often is this present?

Severity:

Have you received care for this problem before?
○ Yes ○ No

How would you describe this problem?

☐ Sharp ☐ Dull ☐ Ache ☐ Sore ☐ Spasm ☐ Numbness ☐ Tingling ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stiff ☐ N/A

What makes the problem better?

What makes the problem worse?

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How are your symptoms/conditions interfering with your life? (select all that apply)

☐ Affects my work/ability to work ☐ Cannot exercise like I want ☐ Limits my hobbies or recreational activities
☐ Affects my relationships ☐ Affects my sleep and rest ☐ I struggle to take care of myself ☐ Affects my energy levels
☐ Limits my productivity or creativity ☐ Impacts my attitude and patience

How committed are you to correcting the underlying issues?

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	Other Health Concerns	Severity (1-10)	How long have you had this?	Did this start with an injury?	Have you had this before?	Constant or Comes/Goes
1						
2						

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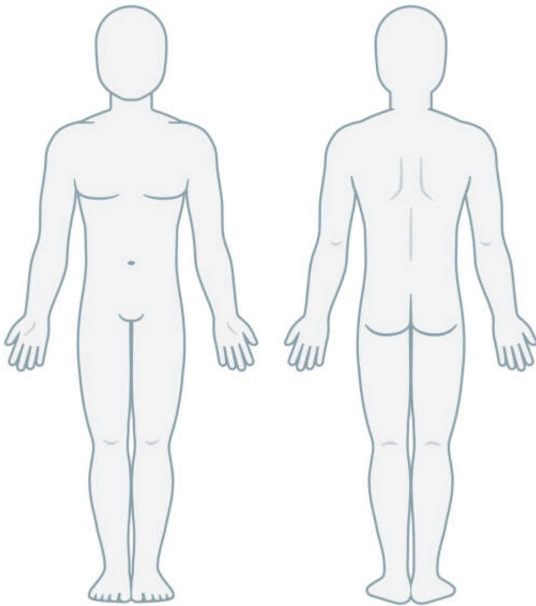
Please indicate which type and where you are experiencing your primary health concern.

Pain | Numbness/Tingling | Stiffness



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Please list any significant family medical history:

TRAUMAS: Physical Injury History

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Have you ever had any significant falls, or surgeries as an adult?

○ Yes ○ No

If yes, please explain:

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Any auto accidents?

○ Yes ○ No

Please list (include type and year):

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Did you participate in any youth or college sports?

○ Yes ○ No

Please list any major injuries:

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Notable childhood injuries?

○ Yes ○ No

Please explain:

TOXINS: Chemicals & Environmental Exposure

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Please rate your consumption for each:

	1 - None	2	3 - Moderate	4	5 - High
Water	○	○	○	○	○
Alcohol	○	○	○	○	○
Tobacco	○	○	○	○	○

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Please list any medication you are taking and reason for taking it.

	Medication	Reason	Date Started
1			
2			

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Please list any vitamin/supplements and the reason for taking it.

	Vitamin/Supplement	Reason
1		
2		

THOUGHTS: Emotional Stresses & Challenges

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Please rate your stress for each:

	1- None	2	3 - Moderate	4	5 - High
Home	○	○	○	○	○
Work	○	○	○	○	○
Life	○	○	○	○	○
Money	○	○	○	○	○
Health	○	○	○	○	○
Family	○	○	○	○	○
Other	○	○	○	○	○

If "other' please list here:

LIFESTYLE

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How many hours do you sleep on average?

○ 5 or fewer ○ 6-8 hours ○ 9 or more hours

Do you wake up:

○ Refreshed and ready ○ Groggy and tired ○ Stiff and sore

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Rate your level of daily activity and/or exercise:

How many hours per day do you typically spend sitting at a desk, in a car, or on an electronic device?

○ Less than 2 hours ○ 2-5 hours ○ 6 or more hours

Click the right arrow to continue to the next page...

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

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CARDIOVASCULAR

	Past	Present
Blood Clots	☐	☐
Cold / Blue Fingers or Toes	☐	☐
Chest Pain	☐	☐
Heart Palpitations	☐	☐
High Blood Pressure	☐	☐
Swelling in Hands / Feet	☐	☐

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CONSTITUTIONAL

	Past	Present
Fever	☐	☐
Night Sweats / Chills	☐	☐
Sudden Weight Loss or Gain	☐	☐

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HEENT

	Past	Present
Ear Infections	☐	☐
Ringing in Ears	☐	☐
Sinus Congestion	☐	☐
Sore Throat	☐	☐
TMJ / Jaw Pain	☐	☐
Vertigo	☐	☐

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IMMUNOLOGIC

	Past	Present
Autoimmune Condition	☐	☐
Food Intolerance / Seasonal Allergies	☐	☐
Eczema / Skin Conditions / Rash	☐	☐

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GASTROINTESTINAL

	Past	Present
Acid Reflux / Heartburn	☐	☐
Abdominal Pain / Bloating / Swelling	☐	☐
Constipation / Diarrhea	☐	☐
Nausea / Vomiting	☐	☐

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GENITOURINARY

	Past	Present
Bladder & Urination Issues	☐	☐
Fertility Challenges	☐	☐
Ovarian / Uterine Issues	☐	☐
Prostate Issues	☐	☐

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MUSCULOSKELETAL

	Past	Present
Arthritis	☐	☐
Joint Stiffness	☐	☐
Muscle Weakness / Cramping	☐	☐

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NEUROLOGIC

	Past	Present
Concussions	☐	☐
Headaches / Migraines	☐	☐
Incoordination	☐	☐
Numbness / Tingling Sensations	☐	☐
Paralysis	☐	☐
Seizures	☐	☐
Syncope / Fainting	☐	☐
Tremors	☐	☐

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PSYCHOLOGICAL

	Past	Present
Anxiety	☐	☐
Depression	☐	☐
Focus / Attention / Concentration Issues	☐	☐
Sleeping Difficulties	☐	☐

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RESPIRATORY

	Past	Present
Asthma	☐	☐
Bronchitis or Pneumonia	☐	☐
Chronic Cough / Colds	☐	☐
Shortness of Breath	☐	☐

ACKNOWLEDGEMENT & CONSENT

By signing this form electronically, and clicking on "Submit Signature", you are agreeing to the terms stated herein.
e-signature

Signature: ______________________ Date: ______________________