NEW PATIENT INFORMATION

Please print clearly and complete all questions

Name:	Date:
Address:	City/State/ZIP:
Home Phone:	Work Phone:
Cell:	E-Mail:
Occupation:	❑Full time ❑Part time ❑Retired ❑Unemployed
Employer:	Is it okay to contact you at work? ❑Yes ❑No
Who may we thank for referring you?	
Birth Date:	Age: Sex: ❑Male ❑Female ❑:
Marital Status: ❑Single ❑Married ❑Separated/Divorced ❑Widowed Spouse's Name: Number of children / age(s): /	Number of grandchildren / age(s): /
Is there any possibility you may be pregnant? ❑Yes ❑No ❑Not sure	
Emergency Contact Name and Phone Number:	
What is your most important current goal?	
Favorite Hobbies or Interests:	
Method of Payment for First Visit: ❑Cash ❑Check ❑Credit Card ❑CareCredit ❑Gift	

Date of Last Chiropractic Adjustment: _____

When was your most recent spinal check up? ❑ Never ❑ 6 months or less ❑ 6 to 12 months ❑ 12 months or longer

Current health concerns/reasons for consulting our office:

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

Have you had same or similar problem(s) before? ❑Yes ❑No If yes, for how long?_____

Is this the result of an auto or work injury? ❑Yes ❑No If yes, when?_____

Do you have an immediate relative with similar problems? ❑Yes ❑No If yes, who?_____

Other doctors you have seen for this problem:_____

Surgeries you have had:_____

Have you ever been diagnosed with: Cancer?❑Yes(type?_____) ❑No

Heart Disease?❑Yes ❑No Stroke?❑Yes ❑No

Rate your level of physical activity: ❑High ❑Medium ❑Low Please describe:_____

_____

Rate your Stress Level: *(low)* 1 2 3 4 5 6 7 8 9 10 *(high)*

The above information is true and accurate to the best of my knowledge. I understand that the doctor will not perform a spinal adjustment or manipulation until a thorough review of medical history and spinal examination has been administered. I authorize Network Chiropractic Wellness Center to render necessary services to me and understand that I am responsible for all charges incurred.

Patient or Guardian Signature: Date:

CONTINUE ON BACK ...

Physical Stresses

❏ Auto accidents _____

❏ Falls/broken bones/ sprains _____

❏ Spinal injuries/epidural _____

❏ X-rays/CT/MRI Scans _____

❏ Repetitive postural stress - sitting/standing/computer work _____

❏ Physical abuse/violation/assault/attack _____

❏ Extensive dental work/braces/extractions _____

❏ Allergies_____

❏ Dizziness/earaches or ringing_____

Chemical Stresses

Past/Present Medications (Blood Pressure, Pain, Anti-Depressants, Hormonal, Ritalin, Antibiotics, etc)

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ _____ for _____ ❏ _____ for _____

❏ Birth Control ❏ Flu shot ❏ Childhood or other vaccines/travel ❏ Adverse reactions to vaccinations

❏ Substance Abuse: _____ ❏ Past ❏ Present ❏ AA ❏ NA ❏ Other:_____

Do you regularly use?:

❏ Alcohol ❏ Tobacco ❏ Caffeine ❏ Marijuana ❏ LSD ❏ Psychedelics ❏ Cocaine ❏ Ecstasy ❏ Other:_____

❏ Fast food/processed food ❏ Artificial sweeteners/diet sodas/food additives

❏ Occupational exposure to chemicals/fumes

❏ Other _____

Mental/Emotional Stresses

❏ Childhood stress ❏ Family stress ❏ Loss of loved ones ❏ School stress ❏ Post-partum depression

❏ Mental/emotional/sexual abuse ❏ Stress of moving home/family/school ❏ Stress of being ill/pain/surgery

❏ Lack job satisfaction/success ❏ Relationship/love/intimacy issues ❏ Separation/ divorce (self or parents)

❏ Watching TV _____ hr/week ❏ Internet ___ hr/day ❏ Other emotional situations _____

Network Chiropractic
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