New Patient Application

(Please Print)

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

Patient Information:

Full Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Best Phone: Home: _____ Cell: _____ Other: _____

Date of Birth: _____ /_____ /_____ Age: _____ Occupation: _____ Sex: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Homemaker ☐ Unemployed

Your employer: _____ Phone number: _____

Employer's address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partnership

Their Name: _____ Their Employer: _____

Children's names & ages: _____

Previous Chiropractor: _____ Last Visit: _____

Address: _____ Reason for consulting that office: _____

What type of care did you receive?

☐ **Relief Care** (Symptom relief of pain or discomfort) ☐ **Corrective Care** (Correcting, relieving and stabilizing spinal, joint and postural issues) ☐ **Wellness Care** (Maximizing the body's ability for optimal healing and function)

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone: _____

General Practitioner: _____

Address: _____ Phone: _____

May we send a report of your findings to this Practitioner? ☐ Yes ☐ No

Favorite hobbies or interests: _____

Who may we thank for referring you? _____

Reason(s) for consulting our office (in order of severity):

1. _____ 3. _____

2. _____ 4. _____

Is this condition getting progressively worse? ☐ Yes ☐ No When did it start? ___/___/___

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

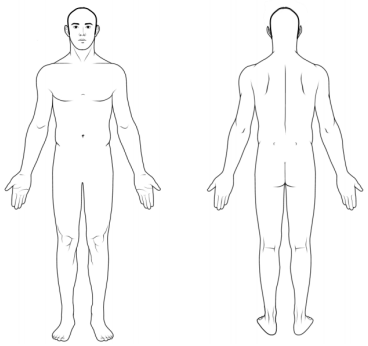
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

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

Mark an "X" on the picture where you have pain, numbness, or tingling.



- over -

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Are you wearing: ☐ Heel Lifts ☐ Custom Orthotics Height: _____' _____" Weight _____ lbs.

Have you had any X-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No Facility:_____

Date Taken:_____ What areas were taken?_____

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

Other doctors who have treated this problem:_____

Father/Mother/Brother/Sister/Children with similar problems? _____

Have you had same or similar problem(s) before? ☐ Yes ☐ No How long? _____

Surgery you have had: _____

Medications/Supplements you currently take: _____

_____

List allergies/sensitivities: _____

Indicate if you have <u>now</u> or <u>ever had</u> any of the following:

☐ Abnormal Weight Gain/Loss	☐ Fatigue	☐ Muscle Stiffness worse w/activity	☐ Sciatica
☐ Alcoholism	☐ Fractures	☐ Neck Pain or Stiffness	☐ Stroke
☐ Allergies	☐ Frequent Urination	☐ Numbness/Tingling Arms/Legs	☐ Surgical Fusion
☐ Arteriosclerosis	☐ Glaucoma	☐ Osteoporosis	☐ Tumors, Growths
☐ Arthritis	☐ Headache/Migraine	☐ Osteopenia	☐ Visual Disturbances
☐ Asthma	☐ Heart Disease	☐ Pacemaker	☐ Other_____
☐ Bruise Easily	☐ Herniated Disk	☐ Pain Unrelieved by Position/Rest	_____
☐ Cancer	☐ High Blood Pressure	☐ Pinched Nerve	_____
☐ Celiac Disease	☐ High Cholesterol	☐ Pregnancy	_____
☐ Chemical Dependency	☐ Joint Stiffness on rising	☐ Prostate Problems	_____
☐ Depression	☐ Menstrual Problems	☐ Prosthesis	_____
☐ Diabetes	☐ Multiple Sclerosis	☐ Psychiatric Care	_____
☐ Dizziness	☐ Muscle Cramps at night	☐ Recent Fever	_____
☐ Epilepsy/Seizure	☐ Muscle Cramps w/exercise	☐ Rheumatoid Arthritis	_____

<u>EXERCISE</u>	**<u>WORK ACTIVITY</u>**	**<u>HABITS</u>**		**<u>SPECIAL DIET</u>**
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____	☐ Vegan
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____	☐ Vegetarian
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day_____	☐ Other:_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason_____	

Top 3 health goals: 1_____ 2_____ 3_____

What have you heard about chiropractic? _____

Do you know what a subluxation is? If yes, please describe. _____

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

Do you have health insurance? Yes / No Insurance Company_____ Additional insurance? Yes / No

Method of payment for first visit: ☐ Cash ☐ Check ☐ Debit ☐ Credit Card

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

_____ _____

Patient or Guardian Signature Date