NEW PATIENT APPLICATION

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

Name:____ Today's Date:____________________

Address:____ _______________________

City/State/Zip:____ E-Mail:_____________________________

Phone: Home ________________________________ Work:____

Cell #:______________________________________ Marital status: M/W/D/S

How would you prefer to receive appointment reminders?

☐ Phone call ☐ Email ☐ Text

Birthdate:________/_______/_________ Age:_________ Social Security #:_______________________

Occupation:____ ________________________

Employer name: ____ Phone: ____________________________

Employer's address:____ ____________

Spouse's name:____ ______________

Spouse's employer:____ ______________

Who may we thank for referring you? ____

Your prior Doctor of Chiropractic:____ __

City, State: ____________________________________

Chiropractic adjusting techniques you've had success with:___________________________________

Last time you went to previous Doctor of Chiropractic: _______________________________________

General Practitioner name:_______________________________ Phone: ______________________________

Address, City, State: ____ __

Please rate on a scale of 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP: ________________________

Other Specialists you are currently under care with:

Name: ____ Phone: ________________________

Name: ____ Phone: ________________________

Name: ____ Phone: ________________________

Children's names & ages:__________________

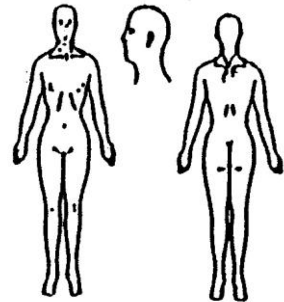
____

Favorite hobbies or interests:____________________________________

Mark area(s) of

Health Concerns

____



Health reasons for consulting our office:

1.__________________________________ 2.____________

3.__________________________________ 4.____________

Have you had same or similar problem(s) before?___Yes

How long?: ______________ Please explain:

____

____

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

____ ________________________

Is this the result of an auto or work injury?_______If so, when? ________________

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

____ _________________________

Other doctors who have treated this problem:____

____ _________________________

Surgery you have had (ALL):____

Medication(s) you currently take:____

Is there any chance you are pregnant? Yes_____ No______

What do you understand chiropractic care to be?

____ _________________________

Do you know what a subluxation is? Yes or No If yes, please describe:

____ _________________________

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

Have you ever been diagnosed with cancer?___ If so, what type?
____
____

Do you have health insurance?____________ Name of company:___________________________

Name of Policy Holder ________________________ Relationship (self,spouse,parent) ______

Insured DOB_______________ Insured SS#______________

Method of payment for first visit:

_____Cash _____Check _____MAC _____Credit Card

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.

Patient or Guardian Signature:__________________________ Date:__/__/__

Authorization of Release:

We at McCormick Chiropractic firmly believe that open communication between all of your Doctors is vital to optimal care being rendered. Therefore, we respectfully request your permission to forward relevant information to the above stated Doctors.

Permission to forward relevant information regarding my care to the above stated doctors.

Patient's signature: ____