# New Patient Application

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

Name:______________________________ Today's Date:________________

Preferred Name: ______________________ Birthdate: ____/____/____ Age:________

Address:______________________________________ Email:_______________________________

City/State/Zip:_________________________________ Social Security #: ___________________

Phone: Home:_________________ Work:__________________ Cell:__________________________

Status: Married / Widow / Divorced / Single / Other:_________________________________

Who may we thank for referring you? ___________________________________________________

Occupation: ______________________________

Employers name: ______________________ Phone: _____________________

Spouse's name: ___________________________ Phone:______________________

Spouse's employer:_______________________ Phone:______________________

Children's names & ages:______________________________________________________________

Emergency Contact: ______________________ Phone: _________________ Other: ___________

Favorite hobbies or interests: ___________________________________________________________

Your Prior Doctor of Chiropractic: ______________________________________________________

City, State: ___________ Approximate date of last Chiropractic treatment: ______________

Chiropractic adjusting techniques you've had success with: ____________________________

General Practitioner name: ______________________________________________________________

Phone:___________________ City, State: _______

Please rate 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:_________________________

Method of payment for first visit

____ Cash ____ Check ____ Credit Card

Person Responsible for payment:

Name: _______________________________

Phone Number:__________________________

Address: ______________________________

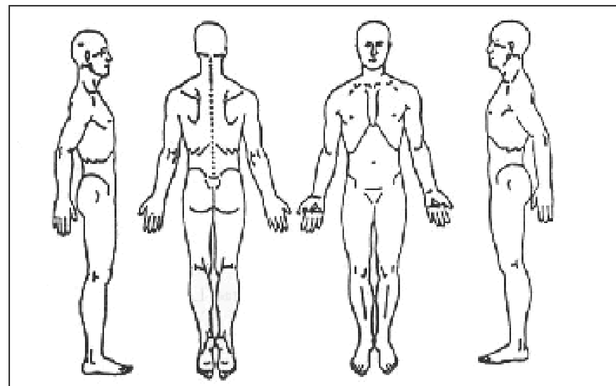
City:______________________________

State/Zip:_____________________________

Do you have Health (crisis) Insurance? Y N

Insurance Company: ____________________

**Mark Area(s) of Health Concerns**:



*Office: (757) 399-4700* *Fax: (757) 399-0011*

Health reasons for consulting our office:

1.________________________________________ 2. ________________________________________

3.________________________________________ 4. ________________________________________

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

How long?________________ Please explain:____________________________________________

______________________________________________________________________________________

Does this condition interfere with your: ____work ______sleep ___ daily routine__________________
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 Insurances requires you to see in the first 90 Days? If so, who?__________________________________________

Other doctors who have treated this problem: _______________________________________________

What treatments did you receive: __________________________________________________________

Medication(s) you currently take: __________________________________________________________

______________________________________________________________________________________

Do you take supplements? Yes or No If yes, please list______________________________________

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:

______________________________________________________________________________________

Do you play any sports or exercise regularly? Yes or No If yes please describe______________________

______________________________________________________________________________________

Do you smoke? Yes or No If yes how many cigarettes/packs a day?________________________________

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: ___________________________ Motorcycle accidents: ___________________________

Falls or other injuries: ______________________ Spinal or neck injuries: __________________________

Broken Bones: ____________________________ Knocked unconscious: __________________________

Surgeries: _________________________________ Health problems of parents: ______________________

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Carpal Tunnel ___Cancer ___Diabetes ___Emphysema ___Gout ___Heart Disease ___High Blood Pressure ___Kidney Disease ___Low Blood Pressure ___Migraines ___Numbness/tingling ___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid disorder ___Tuberculosis ___Ulcers

*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: __/__/__

*Office: (757) 399-4700* *Fax: (757) 399-0011*

OLDE TOWNE FAMILY CHIROPRACTIC

**Patient Authorization regarding chiropractic care provided in an "education driven" environment**

It is the practice of this office to provide chiropractic care in an "education driven" environment. Education driven adjusting involves a learning environment for a community of patients being cared for in a common adjusting room. Patients are within sight and hearing range of one another thus profoundly deepening the competency of how your ability to learn can enhance your recovery. A private or confidential setting is always available and accessible should such a less recovery centered and more exam or history driven exchange be necessary.

We provide the ability to protect you from "incidental disclosures" of health information by reminding you that if you wish to speak on private matters we may request a separate though less educationally productive and beneficial setting. Research has proven that the leading cause of death in the world is poorly made decisions. For this reason, even though it is more demanding upon the doctors and staff, we uphold the disciplines to function in this educationally driven setting so you can hear and learn from more exchanges and examples of ideal health care. In many instances, it is evident that doctors need to educate people may quite possibly be more important than caring for them if we are truly dedicated to making sustainable advances in healthcare.

Please grow your deliberateness at keeping your ears and eyes open and engaged with what every doctor and patient is asking and responding to. These actions will help you get well faster, stay well longer, stop perpetuating previous habits which may have been counterproductive to true health care and more.

Your signature indicates your understanding of this more deliberate and advanced approach to your appointments.

______________________________________________________________________

Name (Printed) Signature Date

**Cancellation/No-Show Policy for Saturday Appointments**

It is the policy of this office that if you find it necessary to cancel or change a Saturday appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a $55.00 cancellation fee.

______________________________________________________________________

Signature Date