TLC CHIROPRACTIC 907 Easton Rd. Willow Grove, PA 19090 215-657-3200

NEW PATIENT APPLICATION

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

Patient Name_____ Today's Date_____

Birthdate_____ Age_____ Sex M / F E-Mail_____
Address_____City_____ State____Zip_____

Phone_____ Cell_____ Work_____

Occupation_____ Your Employer_____
Employer's Address_____

Marital Status: Married/Widow/Divorced/Single/Partner Their Name_____
Children's Names & Ages _____

Prior Chiropractor_____ Last appointment_____
Address_____ Phone_____

General Practitioner_____
Address_____ Phone_____
May we send a report of your findings to this Practitioner? ___Yes ___ No

Other Physicians you see regularly: _____
OB/GYN ☐ Rheumatologist ☐ Neurologist ☐ Endocrinologist ☐
Cardiologist ☐ Orthopedist ☐ Other ☐

Favorite Hobbies or Interests _____

Who may we thank for referring you?_____

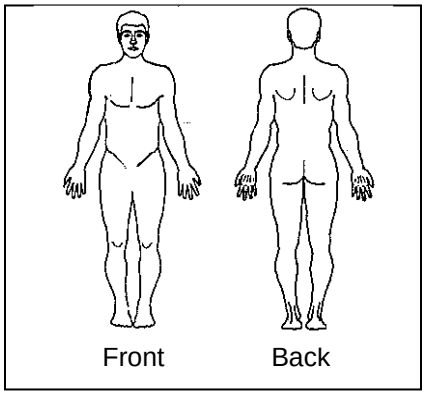
Please check the boxes next to any social media platforms you saw our practice on:
Google☐ Facebook ☐ Instagram☐ Youtube ☐

Health Reasons For Consulting Our Office:

1._____ 3._____

2._____ 4._____

Mark area of Health Concerns



Current Complaint (how you feel today): Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ___ 0-25% ___26-50% ___51-75% ___76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities?
(for example: work, social activities, household chores) Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Have you had any X-rays, MRI, CT Scan for your area(s) of complaint? ___Yes ___No

Date Taken_____ What areas were taken?_____

Is this the result of an auto injury? ___Yes ___No work injury? ___Yes ___ No

If so, when? _____

Other Doctors who have treated this problem_____

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

Please check all of the following that apply to you.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)_____
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Osteoporosis
___Prostate Problems
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___Epilepsy/Seizures

___Tobacco Use – Type_____Frequency_____/Day

___Cancer/Tumor (Explain)_____

___Surgeries_____

___Medications_____

___Other Health Problems (Explain)_____

___None of the Above

What have you heard about chiropractic?_____

Do you know what a subluxation is? ___Yes ___No

If yes, please describe_____

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

Do you have health insurance? ___Yes ___No Insurance Plan_____

Method of Payment for First Visit: ___Cash ___Check ___Credit Card

Emergency contact: _____ _____ _____
Name Relationship Phone Number

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:_____