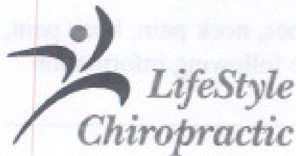

# New Patient Application

Date ___________________

SS#___________________ Email ___________________@___________

Full Name ___________________ Birth Date___/___/___ Ht:______ Wt:______

Address ___________________________________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Occupation ______________________ Employer ______________________

You Are: Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Spouse's Name ______________

Heard About Us/Referred To Our Office By ___________________________

Family Physician ______________ Phone #______________ Last Visit ______________

Describe your main complaint______________________ Started When?______________

Was this problem caused by: Car Accident ____ Work Injury____ Other______________

What treatment have you had for this problem? ___________________________

This problem has been: Getting Better ( ) Getting Worse ( ) Staying The Same ( )

Are you taking any prescription medications? _____ For What? ______________

Have you seen a chiropractor in the past? _______ When?______________ For What?______________

**For each condition listed below, place a check in the appropriate column**

| | Past | Present | | Past | Present | | Past | Present |
|---|---|---|---|---|---|---|---|---|
| Arthritis | | | Dizziness | | | Kidney Problems | | |
| Asthma | | | Epilepsy | | | Measles | | |
| Anemia | | | Excessive Thirst | | | Multiple Sclerosis | | |
| Abdominal Pain | | | Fibromyalgia | | | Muscular Dystrophy | | |
| Back Pain | | | Frequent Urination | | | Numbness | | |
| Cancer | | | Hand/Wrist/Arm Pain | | | Prostate Problems | | |
| Chest Pains | | | Headaches/Migraines | | | Rheumatic Fever | | |
| Concussion | | | Heart Attack/Heart Problems | | | Sciatica | | |
| Depression | | | Hepatitis | | | Seasonal Allergies | | |
| Diabetes | | | High Blood Pressure | | | Stroke | | |
| Digestive Problems | | | HIV/Aids | | | TB | | |

List all surgical procedures you've had and the dates ___________________________

___________________________________________

___________________________________________

Are there any diseases or conditions that are common among or have been diagnosed with family members? ______

___________________________________________

If you have a family member or friend that is experiencing any unresolved conditions such as migraines, neck pain, back pain, muscle spasms, etc., and would like us to contact them and see if we can help them, please provide the following information.

Name ______________________ Condition ______________________ Phone ______________

Name ______________________ Condition ______________________ Phone ______________

Name ______________________ Condition ______________________ Phone ______________

Have you been diagnosed with rheumatoid arthritis? ___yes ___no

Have you been diagnosed with any bleeding disorders? ___yes ___no

Are you taking blood thinners? ___yes ___no

Have you been diagnosed with any circulatory disorders? ___yes ___no

Have you been diagnosed with any disc herniation(s)? ___yes ___no

Have you had any broken bones, including spinal vertebrae? ___yes ___no

Are you taking birth control pills? ___yes ___no

Do you have any surgical implant devices? ___yes ___no

Would you like to schedule a complimentary scoliosis screening for your child? ___yes ___no

Do you currently have a regular exercise routine? ___yes ___no

Have you recently considered starting an exercise program to become more physically fit? ___yes ___no

Would you like guidance or ideas on how to progress with your current exercise program? ___yes ___no

Which of the following exercise programs would be of interest to you?

___running ___swimming ___treadmill ___water aerobics ___impact aerobics ___non-impact aerobics

___pilates ___weight training ___massage ___racquetball ___martial arts ___walking ___elliptical

Other: ______________________________________________

Have you ever considered a personal trainer for assistance with your workout program? ___yes ___no

If yes, would you like to schedule a complimentary consultation with a personal trainer ___yes ___no

If available, would you like a complimentary guest pass to the Lexington Athletic Club? ___yes ___no

## *Patient Comments*

*Please enter any additional information you would like to bring to the doctors attention:*

______________________________________________

______________________________________________

______________________________________________

**Print Patient Name:** ______________________________________________

**Patient/Legal Guardian Signature:** ______________________ **Date** ______________