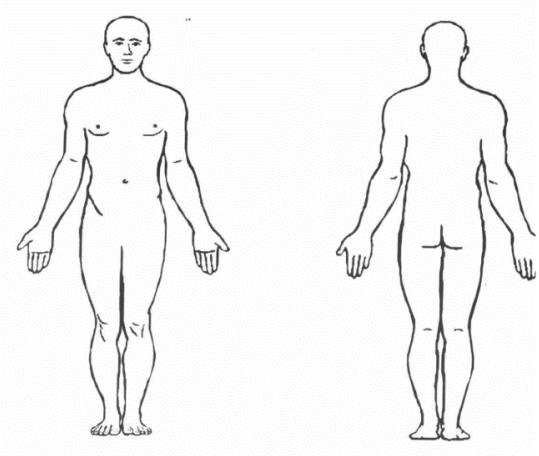
NEW PATIENT ADMITTANCE FORM		
Contact Information		
First name:	**Last name:**	
Address:		
City:	**Postal Code:**	
Mailing address (If different):		
Preferred Phone (circle one): Cell Home Work		
Cell:	**Home:**	**Work:**
Email:		
Subscribe to mailing list for upcoming promotions, giveaways, and events? YES Please! No Thanks		
Family doctor contact:		
Emergency Contact:		
Personal Information		
DOB:	**Age:**	**Sex:**
Height:	**Weight:**	**Activity Level:**
Occupation:		
Health History		
Reason for appointment:		
When did your condition begin?		
Have you had similar issues in the past?		
Have you had Xray, MRI, or other testing for this condition? (Explain):		
Work related? Yes No	**Motor Vehicle Accident? Yes No**	**Date of Injury:**
Can you perform daily activities? Yes Yes, with help Not at all		
Can you perform work activities? All activities Only some Not at all		
Describe your stress level: High Moderate Mild None		
Please list previous surgeries, illnesses, injuries:		
Please list all prescription and non-prescription medication, vitamins, and supplements:		
Have you received chiropractic care before? Yes No	**Doctor:**	**Date:**
Please explain any other questions and concerns:		

Patient name:		
Date of New Patient appointment:		
Please indicate whether you have been diagnosed with any of the following:		
High blood pressure (hypertension)	Yes	No
Hardening of the arteries (atherosclerosis)	Yes	No
Diabetes Type 1	Yes	No
Diabetes Type 2	Yes	No
Tuberculosis	Yes	No
Cancer (please specify):	Yes	No
Heart disease	Yes	No
Blood disease	Yes	No
Bone spurs on cervical/neck bones (cervical sprain)	Yes	No
Whiplash injury (flexion-extension injury and/or cervical sprain)	Yes	No
Stroke or family history of stroke (please specify):	Yes	No
Visual disturbance (blurring, double vision, loss of vision)	Yes	No
Hearing disturbances (loss, ringing, other noises)	Yes	No
Slurred speech or other speech issues	Yes	No
Difficulty swallowing	Yes	No
Dizziness, loss of consciousness, or blackouts (please specify):	Yes	No
Sudden collapse without loss of consciousness	Yes	No
Numbness, loss of sensation, decrease in strength/muscle weakness (please specify sensation and location):	Yes	No

Please indicate the location of pain by shading the appropriate area(s):



Describe type of pain: dull, sharp, radiating, hot, spasm, aching, cramping, shooting, burning, tender, throbbing, tiring, gnawing, stabbing,

other:_____

Indicate the severity of pain:

No pain 1 2 3 4 5 6 7 8 9 10 Extreme pain