New Patient Application

Welcome to NYC Corrective Chiropractic Care, P.C.

In order to provide the best possible care, please complete as thoroughly as you can.

Personal Information

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ Email: _____

Contact Number: _____ Birthdate: _____ Age: _____

Marital Status: S M D Social Security #: _____

Employer: _____ Work Phone: _____

Address: _____ Occupation: _____

Health Insurance Co./ID#: _____

Who may we thank for referring you?: _____

Have you ever been to a Chiropractor?: Yes No If yes, date of last visit & name of chiropractor:

_____.

Last time you went to your prior Chiropractor?: _____

Your General Practitioner/City?: _____

Date of your last physical exam?: _____

Spouse/Domestic Partner Name: _____

Occupation/Employer: _____

Health History

What is your reason(s) for consulting us?: _____

Have you had similar issue(s) before?: Yes No

How Long?: _____ Please Explain: _____

Have other Doctors treated this issue(s)?: Yes No

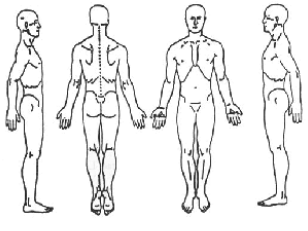
Any family members with similar issue(s)?: Yes No If yes, who? _____

Have you ever had cancer?: Yes No If yes, what type(s)? _____

Have you had any surgery(s)?: Yes No If yes, please list.

_____

Please mark area of discomfort, pain or concern



Is there a chance you could be pregnant?: Yes No

Have you had x-rays of your spine taken?: Yes No

If yes, how long ago? _____

Please list medications/supplements you take?	Reason/What for?
_____	_____
_____	_____

Family Health History

Mother's Health: _____ Maternal Grandparents Health: _____

Father's Health: _____ Paternal Grandparents Health: _____

Children Y N If so, Names/Ages: _____

Children's Health: _____

Medical History

Have you ever…			When? (approximate year(s))
…broken a bone(s)?:	Yes	No	
…been hospitalized?:	Yes	No	
…been in an auto accident?:	Yes	No	
…had sprains/strains?:	Yes	No	
…been struck unconscious?:	Yes	No	
…had surgery?:	Yes	No	

Do you/your…			Please briefly explain
…experience pain every day?:	Yes	No	
…symptoms interfere with your daily life?:	Yes	No	
…wake up with pain at night?:	Yes	No	
…symptoms get worse during certain times?:	Yes	No	
…wear orthotics in your shoes?:	Yes	No	
…find that certain activities aggravate your symptoms?:	Yes	No	
…feel that weather changes affect your symptoms?:	Yes	No	

Additional Information

What have you heard about Chiropractic care?: _____

Do you know what Subluxation is? Yes No

What do you do daily for your spinal health?: _____

_____

Are you aware poor posture may affect your organs, their functions and accelerate spinal degeneration? Yes No

Are you interested in Nutritional counseling?: Yes No

Hobbies and Interests?: Yes No If yes, please list: _____

_____

If we are able to accept you as a patient, what would be your number one goal/priority?: _____

_____

Disclaimer

The above information is true an accurate to the best of my knowledge. My reason for a consultation with the Doctor is for evaluation/examination, if necessary, of my spinal/physical health and the potential for improvement.

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself.
I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I am accepted as a patient and I suspend or terminate my care, any fees for professional services rendered to me will be due immediately.

Patient Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____