Discover
Chiropractic
FAMILY HEALTH CLINIC

Pt. #: _____
Date: _____

NEW PATIENT INFORMATION

Name: _____
Address: _____
_____ Phone: _____
Occupation: _____ Phone: _____
DOB: _____ Sex: _____ Marital Status: _____ # of Children: _____
Referred By: _____

Problem Area: _____
Date Problem Began: _____
Similar Problem Previously: _____
Others Seen For This Problem: _____
What Makes This Problem Worse: _____
Other Health Problems: _____
_____

G.P. Name & Address: _____

Have You Been Treated For Any Health Condition In The Past Two Years?
☐ Yes ☐ No Describe: _____
_____

Have You Ever Had Chiropractic Treatment? ☐ Yes ☐ No

Have You Ever Suffered From: (Tick All That Apply)

Dizziness	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Menstrual Problems	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Cystitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	Sleeping Difficulties	☐ Yes ☐ No
IBS	☐ Yes ☐ No	Depression	☐ Yes ☐ No

Symptoms Other Than Listed Above: _____
_____

Please List Any
Serious Falls: _____

Operations: _____

Car Accidents: _____

Other Accidents: _____

Smoking Habits & Duration: _____

Emotional Traumas: _____

Medications Currently Taking: _____

Please Check The Appropriate Boxes:

Male ☐

Female ☐ Pregnant ☐

Possibly Pregnant ☐

Not Pregnant ☐

I AGREE TO ANY RADIOLOGICAL EXAMINATION THAT MAY BE NECESSARY TO PROPERLY DIAGNOSE MY CONDITION.

This clinic operates on a 'payment at the time of visit' policy. Fees are displayed and queries can be made to any member of staff.

The information provided on this form is accurate to the best of my recollection. I have read the payment policy above and agree to allow Discover Chiropractic to examine me for further evaluation.

I understand that chiropractic care from Discover Chiropractic does not cure conditions or disease. What Discover Chiropractic does is find and remove vertebral subluxations. By my signature I hold harmless Discover Chiropratic or any staff member from any liability that might result from chiropractic care under any staff member. Discover Chiropractic agrees to do its very best to help the patient signed below to find and remove subluxations. There are no further guarantees.

Signed: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

☐ 50 + ☐ MALIG ☐ FAILED TO IMPROVE W/ CONSERVATIVE TREATMENT ☐ TRA ☐ POSTURAL ANOMALY ☐ BIOMECH. FINDINGS ☐ NEURO DEF ☐ STEROID USE ☐ D/A ABUSE

☐ WEIGHT LOSS ☐ PYREXIA ☐ EX. PAIN LTD ☐ INFLAM ARTHRO ☐ SCOLIOSIS ☐ SURGERY

OTHER INDICATIONS: _____

RADIOLOGICAL REPORT: _____

_____

_____

_____

_____

_____

_____

SIGNED: _____ DATE: _____