**Journey Chiropractic & Acupuncture**
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# Adult New Patient Application

***"A Healthy Spine Means a Healthier You!"***

Name_______________________________________________Cell Phone ______________________________
Address_____________________________________________Home Phone ____________________________
City, State, Zip_____________________________________________ ____________________________________
E-mail Address ______________________________________________________________________________
Birth date______________________Age______________SS# _________________________________________
Occupation___________________________Employer ______________________________________________
Status: ❍Married ❍Widowed ❍Separated ❍Divorced ❍Single Spouse Name_______________No. of Children _____
To conserve resources we generally utilize email and text for regular communication. May we communicate with you via?
❍Email: ❍Text: ❍ Carrier (like AT&T, Etc.): _____________________________________________
Most patients are referred to our office by a caring family member or friend. What made you to decide to visit our office?
❍Friend ❍Family Member Name: ___________________________________________________________
❍Facebook ❍Google ❍website ❍other_______________________________________________
In case of Emergency, Contact:_________________________________ Phone #__________________________
Relation:___________________________________

## *Please answer the following questions about your health:*

1. Please list your primary health concern you are experiencing:
   1. ________________________ 2.___________________________ 3.______________________________

2. Spinal problems can cause a variety of health problems and impact how your body functions. Please check the health complaint(s) you are currently experiencing or experience on a periodic basis:

| | | | |
|---|---|---|---|
| ❍ADD/ADHD | ❍Circulation Issues | ❍Headaches/Migraines | ❍Reproductive Issues |
| ❍**AIDS/HIV** | ❍Childhood Illnesses | ❍Heart Disease | ❍Ringing in Ears |
| ❍Alcoholism | ❍Depression | ❍**Hepatitis** | ❍Scoliosis |
| ❍Anxiety | ❍Diabetes | ❍Hip Issues | ❍Shoulder Issues |
| ❍Arteriosclerosis | ❍Digestive Issues (*Constipation/ Acid Reflux/GERD/IBS*) | | ❍Stroke |
| ❍Arthritis | ❍Elbow/Wrist/Hand Issues | ❍Immune Deficiencies | ❍TMJ Issues |
| ❍Asthma | ❍Endocrine Issues (*Thyroid*) | ❍Lymphatic Issues | ❍Urinary Issues |
| ❍Cardiovascular Issues | ❍Foot/Ankle Issues | ❍Multiple Sclerosis | ❍Vertigo/Dizziness |
| ❍Cancer | ❍Gout | ❍Osteoporosis | ❍Other ______________ |

3. Auto and work injuries can cause serious spinal problems. Is this visit related to an auto or work injury? ❍ Yes ❍ No
   If yes, explain:_____________________________________________________________________
4. How many auto accidents have you had in your life?__________________________________________

5. Have you ever had any significant falls, surgeries, or other injuries as an adult? **Yes** **No**
   If yes, please explain ______________________________________________________________
   Notable childhood injuries:___________________________________________________________
   High School or College Sports? _______________________________________________________
6. Please list all surgeries: _____________________________________________________________
   _______________________________________________________________________________
7. Are you currently taking prescription medication? ❍ YES ❍ NO If so, how many? ________________
   What are you taking them for?__________________________________________________________
   _______________________________________________________________________________

**Patient Name:** ______________________________________________

8. Research shows that you spine should be checked regularly. When was your last complete Spinal examination?
   ❍within the last year ❍ 1 - 5 years ❍ 5 years or longer ❍ Never
9. Have you had spinal x-rays within the past 3 years? ❍ YES ❍ NO
10. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
   ❍ YES ❍ NO

11. Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? ❍ YES ❍ NO
12. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to twist, stretch or crack your neck, mid or lower spine? ❍ YES ❍ NO
13. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your posture?
   Poor - 1 2 3 4 5 6 7 8 9 10 - Very Good
14. Stress can cause or aggravate spinal problems. Please rate your stress levels over the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High
15. Spinal health is especially important during pregnancy. If female, is there any chance that you are pregnant?
   ❍ YES ❍ NO ❍ MAYBE If yes, when is your due date?____________________Or Date of Last Cycle? ______________

16. Have you ever been diagnosed with cancer? ❍YES ❍NO If so, what kind?_____________Year diagnosed ___________
17. Have you ever had spinal surgery? ❍ YES ❍ NO If yes, where?___________________________________
18. Do you have a pacemaker or metal in your body? ❍YES ❍NO ________________________________________________

19. Our health often impacts our lives and those around us. Which areas are you struggling with because of your condition?
   ❍Work ❍Energy ❍Exercise ❍Attitude ❍Recreation
   ❍Patience ❍Relationships ❍Productivity ❍Sleep ❍Creativity
   ❍Self-Care ❍Other ________________________________________________________________
20. If the doctor feels that you will benefit from chiropractic care and/or acupuncture, are you willing to follow his/her recommendations? ❍ YES ❍ NO
21. How many visits do you think it will take to correct your condition? ____________________________________________

22. How will you be paying for today's visit? ❍ Debit Card ❍ Credit Card (Visa, MC) ❍ Cash ❍ Other__________________
23. Are you Medicare eligible? ❍ YES ❍ NO
24. Is there anything else that you would like to discuss with the doctor? ❍ YES ❍ NO
   If yes, explain:______________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

The above information is true and accurate to the best of my knowledge.

______________________________________________ ______________________
Patient Signature Date

______________________________________________
Signature of guardian if patient is a minor