NEW LIFE CHIROPRACTIC CLINIC

Patient Application

Please fill out the following information in its entirety to allow us the opportunity to better evaluate your case.
If you have any questions, please feel free to ask one of our assistants. Thank You!

Patient Information:

Name: _____ **Preferred Name:** _____ **Date:** ____/____/_____

□ **Male** □ **Female** **Birth Date:** _____/_____/_____ (Age_____) **SS#:** _____-_____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work**: _____

Occupation: _____ **Employer:** _____

Which should we call when necessary? □ Home □ Cell □ Work **Email:** _____

Marital Status: S, M, D, W **Spouses Name:** _____ **Anniversary Date:** _____

Spouses Occupation: _____ **Spouses Phone:** _____

No. of children/Ages: _____

How were you Referred to Our Office: □ Friend/ Family _____, □ Yellow Pages, □ Mail, □ TV, □ Radio, □ Convenient location, , □ Screening, □ Paper/ Article / Report, □ Internet search, □ Other: _____

Type of Care Desired: □ Temporary Relief □ Lasting Correction

Is this visit related to an auto accident or accident at work? □ Yes □ No -When**:** _____

Appointments: Would you like to receive appointment reminders? □ **Yes** □ **No**

-if Yes – □ Phone call, □ Email, □ Text message (who is your service provider: _____)

Insurance Information:

Ins. Company Name: _____ **Phone:** _____

Address: _____ **City:** _____**State:** _____ **Zip:** _____

I.D. #: _____ **Group # (Plan, or Local #):** _____

Subscribers Name (if other than you)**:** _____ **Subscribers SS#:** _____-_____-_____

Relation: _____ **Subscribers Date of Birth:** ____/____/_____ **Employer provided: □ Yes □ No Years:** _____

Health History:

Do you or have you ever had any metal implants? □ Yes □ No locations: _____

Have you been treated by any physician for any health condition in the last 12 months? □ Yes □ No

If Yes, please describe conditions: _____

_____

Surgical History:

Type of Surgery: _____ **Date:** _____

Type of Surgery: _____ **Date:** _____

Type of Surgery: _____ **Date:** _____

Growth and Development during Childhood:

-C-section Birth? □ **Yes** □ **No** -Were you breast fed? □ **Yes** □ **No** -Childhood illnesses? □ **Yes** _____

-Ear infections/ Colic/ Asthma? □ **Yes** □ **No** -Antibiotics? □ **Yes** □ **No** -Attention Deficit Disorder? □ **Yes** □ **No**

-Drugs- prescription, OTC, recreational (circle which)? □ **Yes** □ **No** -Hospitalizations? □ **Yes** □ **No**

-Sports or other physical activities □ **Yes** □ **No** _____-Auto accidents□ **Yes** □ **No** – age? _____

-Injuries during sports? □ **Yes** □ **No** _____

-Did you have any other traumas? □ **Yes** □ **No** _____

-Did you ever break any bones? □ **Yes** □ **No** _____

Current Health Habits:

-Do you smoke? □ **Yes** □ **No** _____ -Do you drink alcohol? □ **Yes** □ **No** _____

-Diet, do you regularly eat healthily? □ **Yes** □ **No** -Drugs- prescription, OTC, recreational (circle which)? □ **Yes** □ **No**

-Jaw/TMJ problems? □ **Yes** □ **No** -Eye problems? □ **Yes** □ **No** -Hearing problems? □ **Yes** □ **No**

-Exercise regularly? □ **Yes** □ **No** _____ -Any Sports injuries? □ **Yes** □ **No**

-Do you sleep well? □ **Yes** □ **No** (hours of sleep) _____ -Sleeping posture? □ **side** □ **stomach** □ **back**

Major Complaints or Symptoms: What are you hoping we can help you with?

Please rate them on a scale of 1 – 10 (with *10 as the worst*)

1. _____ **Rating:** _____ 2. _____ **Rating:** ____

3._____ **Rating:** _____ 4. _____ **Rating:** ____

Pain or Problem started when: _____

Pain is: □ **Sharp** □ **Dull Ache** □ **Constant** and/or □ **Intermittent** □ **Other**: _____

Does this pain radiate, shoot, or travel in your body? □ **Yes** □ **No** -To where? _____

Are you experiencing numbness or tingling in any area of your body? □ **Yes** □ **No** -Where? _____

Since it began, is it: □ **The Same** □ **Better** □ **Worse**

What activities aggravate your condition/pain?

_____

What activities lessen your condition/pain?

_____

Is this condition worse during certain times of the day?

_____

Is this condition interfering with: Work? _____ Sleep? _____Routine? _____Other? _____

Is this condition progressively getting worse? _____

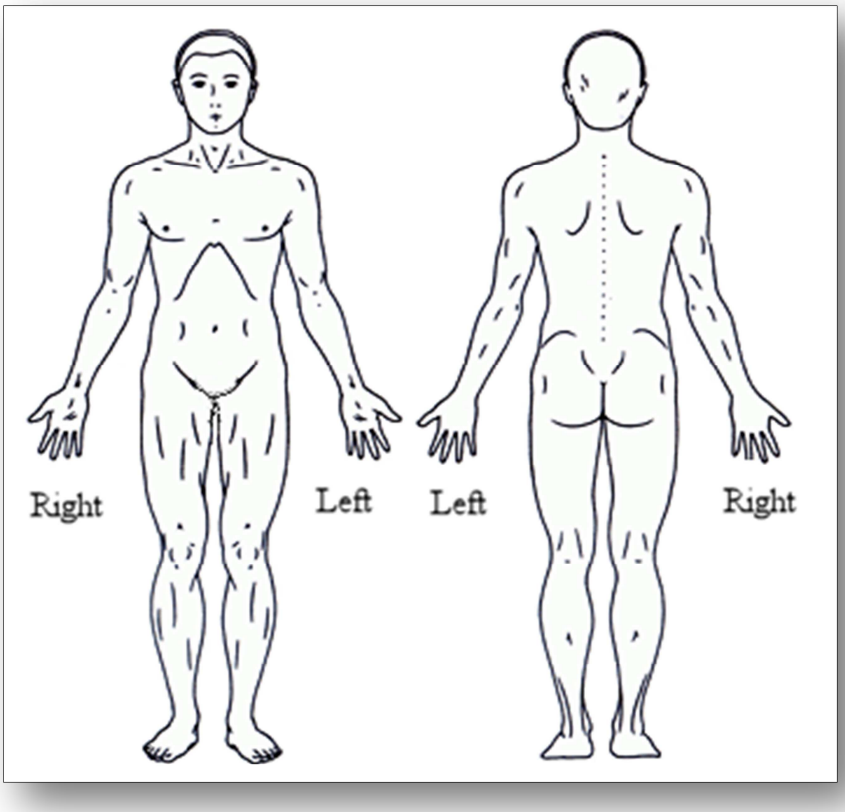
Other Doctors seen for this condition? _____

Attempted any home remedies? _____

Tell us where you feel these symptoms; <u>Mark the pictures</u> where you are experiencing the following:

Please indicate your pain level:

Slight Moderate Severe
(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)



-Sharp/Stabbing

-Dull Ache

-Burning

-Numbness

-Pins, Needles

-Other _____

Please Indicate Any Additional Symptoms You May Be Experiencing:

□ Blurred vision	□ Dizziness	□ Loss of balance	□ Ringing in ears
□ Buzzing ears	□ Face flushed	□ Loss of smell	□ Shortness of breath
□ Cold feet	□ Fainting	□ Loss of taste	□ Stiff neck
□ Cold sweats	□ Fatigue	□ Low resistance to colds/flu	□ Stomach upset
□ Concentration loss	□ Fever	□ Muscle jerking	□ Menstrual cramps
□ Confusion	□ Head seems too heavy	□ Numbness in fingers	
□ Constipation	□ Headaches	□ Numbness in toes	
□ Depression	□ Insomnia	□ Pins/needles in arms	
□ Diarrhea	□ Light bothers eyes	□ Pins/needles in legs	

FEMALES ONLY

Are you pregnant? □ Yes □ No
Are you taking Birth Control? □ Yes □ No Date last menstrual period began: _____

-This is to certify that to the best of my knowledge I am NOT pregnant and Drs. Joshua Blunt & Sarah Nieves Blunt and their associates have my permission to perform any clinical evaluation or technique necessary. I have been advised that x-rays and other deep tissue therapies can be hazardous to an unborn child.-

Signature _____ **Date** _____/_____/_____

Family Health History

Please put check marks (√) on this form to assist the Doctors by providing past & family health histories for future reference.

Condition	Lives locally / Deceased	SELF	SPOUSE ☐ ☐	FATHER ☐ ☐	MOTHER ☐ ☐	SIBLINGS ☐ ☐	CHILDREN ☐ ☐
Allergies							
*** Arthritis**							
Asthma							
Back Trouble							
*** Cancer/type:_____**							
Constipation							
*** Diabetes**							
Disc Problems							
Drug Addiction							
Ear Infections							
Emphysema							
Fibromyalgia							
Headaches							
*** Heart Trouble**							
*** High Blood Pressure**							
Hyperactivity/ ADHD							
Kidney Trouble							
Menstrual Cramps							
Migraines							
Neck Pain							
Nervousness							
Scoliosis							
Pinched Nerve							
Poor Circulation							
Numb Areas -							
Shoulder/ Arm/ Hand							
Hip/ Leg/ Foot							
Sinus Trouble							
Stomach/Digestive Trouble							
Other: _____							