NEW PATIENT APPLICATION

Welcome to King of Prussia Chiropractic & Rehabilitation!

Name:______________________________ **Today's Date:**______________

Address:____

city/state/zip:____

email:____

Phone: home:____________**cell:**______________**office:**______________

Marital Status: m/w/d/s **Height:**_______ **Weight:**________

Birthdate:____________ **Age:**______ **Social Security #:**______________

Whom may we thank for referring you:________________________________

Emergency Contact:________________________**Phone:**______________

Occupation:______________________ **Employer:** __________________

Spouse's name:____________________ **Employer:**__________________

Children's Name & Ages:____

Favorite Hobbies & Interests:____

HEALTH HISTORY *(circle all that apply)*

Did you have any childhood illnesses?	YES	NO
Did you play youth sports?	YES	NO
Was there any prolonged use of medications or Inhaler?	YES	NO
Did you have any surgery?	YES	NO
Were you in any car accidents as a child/teen?	YES	NO
Did you suffer any other traumas (physical or emotional)?	YES	NO
Did you have any serious falls as a child?	YES	NO
As a child, were you under chiropractic care?	YES	NO

Please share any additional information: ________________________________
____

PRESENT HEALTH

Do/ Did you smoke?	YES	NO
Do/ Did you drink alcohol?	YES	NO
Have you been in any car accidents?	YES	NO
If yes, when?____________________________________		
Have you had any surgery?	YES	NO
If yes, what? ____________________________________		
Do/ Did you play adult sports?	YES	NO
If yes, what?____________________________________		
Are you on any medications?	YES	NO
If yes, please list:_______________________________		
Any major slips/falls, physical traumas?	YES	NO
If yes, what?____________________________________		
Do you drink bottled water?	YES	NO

Do you belong to a health club?	YES	NO
Do you take vitamins/ supplements?	YES	NO
Do you watch more than 5 hours of tv a week?	YES	NO
Do you spend more than 1 hour on a computer daily?	YES	NO
Do you drink soda?	YES	NO

CURRENT HEALTH CONCERN

If you have no symptoms or complaints, and you are here for wellness services, please check here:__________

And then skip to the next section.

Please briefly explain what brought you to our office:

____

____

Is this a result of an auto or work injury?__________________ If so, when?______________________

Does this interfere with: ____Work ____Sleep ____Walking ____Hobbies ____Leisure ____Other

Have you seen anyone else for this issue? ____Yes ____No

If yes, who?____

Please Circle all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches Pins & Needles in Legs/Arms Neck Pain Back Pain
Loss of Smell Loss of Balance Dizziness Ringing in Ears Loss of Taste
Numbness in Toes/Fingers Stomach Problems Fatigue Tension
Cold Hands/Feet Muscle spasms/Tightness Sleeping Problems Urinary problems
Menstrual Pain Ulcers Neck Stiffness Constipation/Diarrhea Breathing Problems

PLEASE RATE THE FOLLOWING AS POOR, GOOD, EXCELLENT

Diet:_________________ What do you eat?____

Exercise:______________ When & What?____

Sleep:________________ Hours per day?____

Are their any other health habits that are incorporated into your everyday life?

____

Have you ever been seen by a Chiropractor?__________ Techniques used?____________________

Have you ever been diagnosed with cancer?_________

If yes, what kind?____

Do you have health insurance?________ Name of Company:_______________________________________

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The above information is true and accurate to the best of my knowledge. I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature:____ Date:____________________________