Our mission is to educate and adjust the individual and families towards optimal health through natural chiropractic care.

New Patient Information

Welcome to our office! Please complete all questions

Name: _____Date: _____Pt. #: _office use only_

Address: _____City: _____Zip: _____

Phone (home): _____(work): _____(cell): _____

Birth Date_____ Age: _____ Social Security: _____

E-mail: _____ Marital Status: M S D W

Your Employer: _____Occupation: _____

Spouse Name: _____ Employer:_____

Children's Name and Ages: _____

Activities/Interests: _____

Method of first payment: ☐ cash ☐ check ☐ credit card

Type of Insurance: _____Name of Insured: _____

Insured Birth Date: _____ Insured SS# _____

Current health concern / reason for consultation:

1. _____

2. _____

3. _____

Who may we thank for referring you? _____

Is this a result of an auto accident or work injury? _____

Father, mother, brother, sister, children with similar problems? _____

Medication you are currently taking? _____

Is there a chance you may be pregnant? _____

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

Patient / Guardian Signature _____ Date _____