

Connors Chiropractic Health Center
1935 Washington Street
Stoughton, MA 02072

NEW PATIENT APPLICATION

Welcome to our Practice! **Please thoroughly complete all questions.** Thank you.

Patient Name _____ Today's Date _____

Address _____ E-mail _____

City/State/Zip _____ Birthdate _____ Age _____

Phone _____ Cell _____ Work _____

Occupation _____ Your Employer _____

Employer's Address _____

Marital Status M/W/D/S Spouse _____ Spouse's Employer _____

Children's Names & Ages _____

Prior Chiropractor _____ Last appointment _____
Address _____

General Practitioner _____
Address _____

Favorite Hobbies or Interests _____

Who may we thank for referring you? _____

Health Reasons For Consulting Our Office:

1. _____ 3. _____

2. _____ 4. _____

Have you had similar problem(s) before? ____ Yes ____ No

Current Complaint (how you feel today): Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?

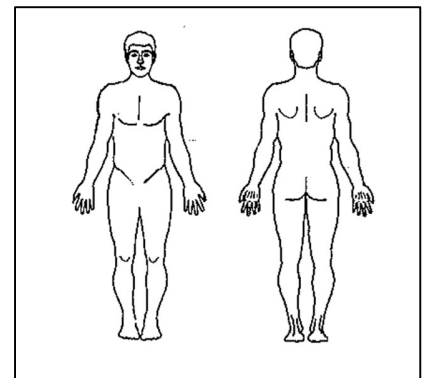
(Occasional) ____ 0-25% ____ 26-50% ____ 51-75% ____ 76-100% (Constant)

How long have your symptoms been present? _____

In the past week, how much has your pain interfered with your daily activities?
(for example work, social activities, household chores) Please Circle

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Mark area of Health Concerns



Front

Back

Is there any chance you are pregnant? Yes No

Have you had any (circle all that apply) X-rays, MRI, CT Scan for your area(s) of complaint?

Yes No Date Taken _____ What areas were taken? _____

Is this the result of an auto injury? Yes No work injury? Yes No

If so, when? _____

Other Doctors who have treated this problem _____

Father/Mother/Brother/Sister/Children, with similar problems? _____

Please check all of the following that apply to you.

Alcohol/Drug Dependence

Recent Fever

Diabetes

High Blood Pressure

Stroke (Date) _____

Corticosteroid Use (Cortisone, Prednisone, etc.)

Taking Birth Control Pills

Dizziness/Fainting

Numbness in Groin/Buttocks

Osteoporosis

Prostate Problems

Menstrual Problems

Urinary Problems

Currently Pregnant, # Weeks _____

Abnormal Weight Gain Loss

Marked Morning Pain/Stiffness

Pain Unrelieved by Position or Rest

Pain at Night

Visual Disturbances

Epilepsy/Seizures

Tobacco Use – Type _____ Frequency _____ /Day

Cancer/Tumor (Explain) _____

Surgeries _____

Medications _____

Other Health Problems (Explain) _____

None of the Above

What have you heard about chiropractic? _____

Do you know what a subluxation is? Yes No

If yes, please describe _____

What daily rituals for spinal health do you presently practice? _____

Do you have health insurance? Yes No Insurance Plan _____

Method of Payment for First Visit: Cash Check Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ Date: _____