IntrinsicCare CHIROPRACTIC

Adult New Patient Application

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Personal Information

Full legal name:			Date:
Address: Street	City	State	Zip
Home phone:		Work phone:	
Cell phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
Height:		Weight:	
Occupation:		Employer:	
Marital status: M S W D		Spouse/guardian name:	
No. of children:		Pregnant?	
Emergency contact (name and number):			
Who may we thank for referring you?			
Do you receive ☐ Medicaid or ☐ Medicare?			

Your confidential answers to all of the questions on this form are to help your practitioner best serve you.

1. Please describe your current health, life and/or functional challenge(s) and limitation(s).

2. What are your top 3 concerns about your pain, circumstance and/or experience?

3. What have you been told about your condition or pain, and what kind of treatment have you received?

4. Please list any significant accidents, injuries, traumas (physical, psychological, social or other) or fears of future harm that you feel may be relevant to where you are at now.

5. Please list any surgeries you have had and the results:

6. Why do you think or believe this has happened to you?

7. If this pain, circumstance, or experience was to go away, what would you like to see replace it?

_____

8. What is this pain, circumstance, or experience asking you to change? What is the message in what's happening?

_____

_____

9. If required, are you willing to make changes in health choices, lifestyle, perspective, or other areas necessary to resolve this concern?

☐ Yes ☐ No If no, what prevents this: _____

List any medications, drugs (prescription **and** non-prescription), shots, or supplements you have taken in the past 6 months and why:

_____

_____

_____

Which best describes your current experience of yourself and your situation? (Rank the top three as 1, 2, 3.)

_____ It seems like nothing works. It seems like it will never end.
_____ I want to get rid of this painful situation. I feel like I need to find the cause.
_____ I feel stuck or blocked and am being held back.
_____ It is time to take my power, life, and/or health back.
_____ I am willing to peel back my illusions, stories, rules, and beliefs and be with whatever is there to find what is real.
_____ I will do whatever it takes, as I am so ready. I can feel and sense the next level.
_____ I accept what has happened, and am ready for resolution. These patterns once served me, and are now outgrown and no longer welcome.
_____ I feel grateful for what has happened and will happen. I am very blessed.
_____ I look for the gift, even in the pain. I realize that we are all connected and everything is purposely organized.

Have you received any type of chiropractic care in the past? ☐ Yes ☐ No **If yes, are you still going?** ☐ Yes ☐ No

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____

What are the highest level outcomes you would like to be initiated as a consequence of your care with us? How would that make your life different?

_____

_____

_____

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____