NEW PATIENT APPLICATION

Welcome to Abingdon Chiropractic Center! Please thoroughly complete all questions.

Patient Name____ Today's Date__________________

Birthdate__________________ Age_____ Sex M / F E-Mail_________________________
Address___________________________________City_____________________ State____Zip________

Phone_______________________ Cell_______________________ Work_______________________
Cell Carrier______________________________ Ok to receive text messages: yes no

Occupation_________________________________ Your Employer____________________________
Employer's Address____

Marital Status M/W/D/S/P Their Name___________________ Their Employer___________________
Children's Names & Ages ____

Prior Chiropractor____ Last appointment______________

Address____ Phone________________

General Practitioner____

Address____ Phone________________

May we send a report of your findings to this Practitioner? ___Yes ___ No

Favorite Hobbies or Interests ____

Who may we thank for referring you?____

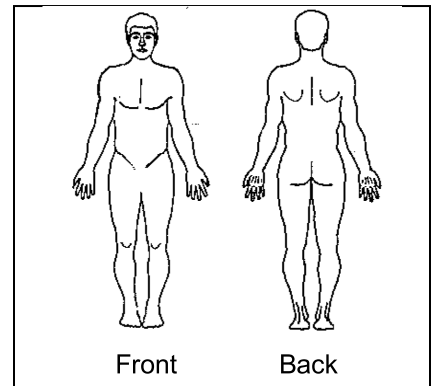
Please check the boxes next to any social media platforms you saw our practice on:
Google☐ Facebook☐ Instagram☐ Youtube☐

Health Reasons For Consulting Our Office:

1.__________________________ 3.___________________________

2.__________________________ 4.___________________________

Mark area of Health Concerns



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)

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

Have you had any 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:________________