



## New Patient Form

*Please complete all questions.*

Today's Date:

Name:	What do you prefer to be called:	
Address:		
City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:
Birthdate:	Age:	Social Security #
Marital Status: M W D S	E-mail address:	
Your Employer:	Occupation:	
Spouse's Name:	Spouse's Employer:	
Children's Names & Ages:		
Emergency Contact:	Phone:	
Who may we thank for referring you to our Practice:		
Previous Chiropractic Care:	Approximate date of last visit:	
Are you here because of a recent auto or work injury?	Date of accident:	
Surgeries you've had:		
Prescription and Over The Counter Drugs Now Taken:		
Ever diagnosed with cancer?	What kind?	
Your Favorite Hobbies:		
<p>Please check the reasons for pursuing chiropractic care:</p> <p><input type="checkbox"/> I'm continuing ongoing care from another chiropractor</p> <p><input type="checkbox"/> I'm interested in wellness and natural health care.</p> <p><input type="checkbox"/> I want to improve my immune function.</p> <p><input type="checkbox"/> I have a specific condition that concerns me. Please explain.</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> I have no idea why I'm here. Please take the time to explain to me what you do.</p>		

**In order for us to better understand you current level of health, please check any of the following body signals which you have or have had previously:**

- Dizziness or Fainting     Headache     Postural Imbalance     Arthritis     Asthma  
 Short Leg/Orthotics     Ear Infection     Intestinal Problems     Frequent Colds  
 Bladder Problems     Sinus Problems     Kidney Problems     High Blood Pressure  
 Menopausal Syndrome     PMS

**Check the Following Conditions the YOU have or have had:  
 Circle conditions that are common to FAMILY MEMBERS:**

- Cancer     Diabetes     Epilepsy     Heart Disease     Lung Disease     Multiple Sclerosis  
 Stroke     Ulcers     Scoliosis     Hyper/Hypothyroidism

## The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation). Which of these stresses do you recognize? Please circle when you experienced these stresses: C (Child) T ( Teenager) A (Adult)

**Physical/ Emotional /Chemical Stress:**

**Comments:**

Birth Trauma	C			
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Sitting on a Wallet		T	A	
Sleeping on Stomach		T	A	
Extensive Computer Work		T	A	
Carrying Heavy Purse/Bookbag/Child		T	A	
Repetitive Lifting/ Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/Standing		T	A	
Children Stress			A	
Career Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/Second Hand Smoke	C	T	A	Amount:
Poor Diet/Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount:
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over The Counter Drugs	C	T	A	

Which do you feel are your primary stresses? \_\_\_\_\_

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Digitized copies are available for a fee.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand Seland Chiropractic Center, P.C. will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Seland Chiropractic Center, P.C. will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment.

It is important that our patients and our office have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

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Patient's Signature

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Date

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Guardian's Signature Authorizing Care for Minor

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Date