

# New Patient Application

## HEALTH4LIFE CHIROPRACTIC

2805 Old Fort Parkway, Murfreesboro, TN 37128

### NEW PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Preferred Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone(\_\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Gender: M / F  
Children's names & Ages: \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Work Phone(\_\_\_\_\_) \_\_\_\_\_  
Type of Work \_\_\_\_\_  
Marital Status S M D W  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Email Address \_\_\_\_\_

### SPOUSE INFORMATION/ EMERGENCY CONTACT

Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Type of Work \_\_\_\_\_  
Phone: Cell(\_\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_\_) \_\_\_\_\_

### EXPERIENCE WITH CHIROPRACTIC

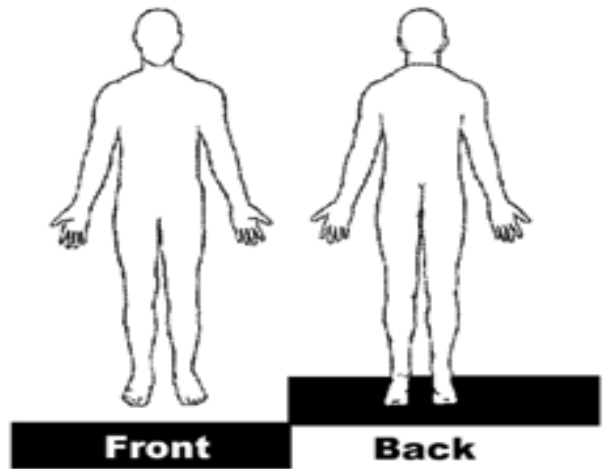
Your Prior Doctor of Chiropractic \_\_\_\_\_  
Chiropractic Techniques you've had success with \_\_\_\_\_  
Date of last visit \_\_\_/\_\_\_/\_\_\_  
Has any adult in your family seen a chiropractor?  Yes  No  
Has any child in your family seen a chiropractor?  Yes  No

### REASON FOR THIS VISIT

Current Health Concerns and Reasons for consulting our office

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Show Us Where It Hurts:** *Please use descriptions when appropriate*  
Numbness (NNN) Pins&Needles (PPP) Burning (BBB)  
Aching (AAA) Stabbing (SSS) Dull Ache (DDD)



Is the purpose of this appointment related to:

- Job  Sport  Auto  Fall  Home Injury  
 Chronic Discomfort  Wellness Check

When did this condition begin? \_\_\_\_\_

Has this condition:

- Gotten Worse  Stayed Constant  Comes and Goes

Does this interfere with:

- Work  Sleep  Daily Routine  Other Activities

Please explain \_\_\_\_\_

Has this condition occurred before?  Yes  No

Please explain \_\_\_\_\_

Have you seen other doctors for this condition?  Yes  No

Doctor's Name \_\_\_\_\_

Treatment \_\_\_\_\_

Results \_\_\_\_\_

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### GENERAL QUESTIONS

Whom may we thank for referring you to this office?

\_\_\_\_\_

Does your mother, father, brother sister or children have

similar problems?  Yes  No

Favorite hobbies or interests \_\_\_\_\_

What lifestyle choices may have contributed to your current state of health? \_\_\_\_\_

Family Physician \_\_\_\_\_

Location \_\_\_\_\_

#### For Women:

Is there any chance you are pregnant?  Yes  No

Do you have breast implants?  Yes  No

### HEALTH HISTORY

1. Surgeries you have had: \_\_\_\_\_
2. Medication(s) you currently take: \_\_\_\_\_
3. Other health problems you have/had: \_\_\_\_\_
4. Have you ever been diagnosed with cancer?  Yes  No If so, what type? \_\_\_\_\_

What do you know or have heard about chiropractic care?

Do you know what a **SUBLUXATION** is? If yes, please describe:

What daily habits for spinal health do you presently practice?

### AUTHORIZATION FOR CARE

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. I hereby authorize the doctor(s) to work with my condition through the use of adjustments to my spine and other therapies as he or she deems appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Guardian or Spouse Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Authorizing Care

**Method of Payment For First Visit:**  CASH  CHECK  CREDIT CARD  HSA