New Patient Application

Welcome to the AWCC Family! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date:_____

Address: _____ City/State/Zip: _____

Email Address: _____ Phone: _____ Home/ Work/ Cell

Patients Birthday: _____ /_____ /_____ Age: _____ Marital status: M / W / D / S

Do you have health insurance? _____ Name of Company:_____

Insurance Policy Holder Name: _____

Policy Holder D.O.B: ____ /____ / ____ Policy Holder Address: _____

Who may we thank for referring you? _____

Your prior doctor of chiropractor and address: _____

Chiropractic techniques you've had success with: _____

Last time you went to previous doctor of chiropractic: _____

General Practitioner: _____ City: _____

Your Employer: _____ Employer Contact Number: _____

Employer's address: _____

Occupation: _____

Spouse's name: _____

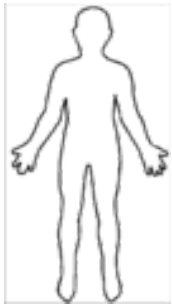
Spouse's Employer: _____

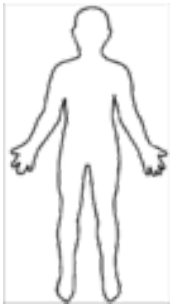
Children's Names & Ages: _____

_____

Mark area(s) of Health Concerns:

Front Back





Health reasons for consulting our office:

1. _____ 2. _____

3. _____ 4. _____

Have you had the same or similar problem(s) before? Yes / No

How long? _____ Please explain: _____

_____

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

_____

Is this problem related to an automobile or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workman's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

_____

Other doctors who have treated this problem: _____

_____

Surgery you have had:_____

Medication(s) you are currently taking: _____

_____

Is there any chance you are pregnant? Yes ____ No ____

Have you ever been diagnosed with cancer? Yes / No If so, what type_____

What have you heard about chiropractic care? _____

_____

Do you know what a subluxation is? Yes / No If yes, please describe:_____

_____

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: _____ / _____ / _____