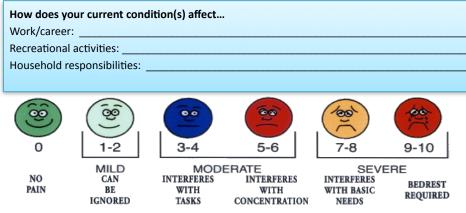


Name:	D.O.B	Acct #:
NEW PA	TIENT APPLICATION FOR CARE 1	/5
Welcome to our Practice! Please thoroughly complete	all questions, printing clearly and allow our staff to photo	copy your driver's license and insurance card.
Today's Date:		
Name you prefer to be addressed by		
Address:	City/State/Zip:	
Race: American Indian or Alaska native / Asian / Black or A	ofrican American / White or Caucasian / Native Hawaiian o	or Pacific Islander / Other / I Decline to Answer
Ethnicity: Hispanic or Latino / Not Hispanic	or Latino / I Decline to Answer Preferred	language:
Marital status: M/W/D/S Gender: M / F	Gender at birth: M / F	
Ever smoked: Y / N How long?	_ How much? If quit, c	late quit//
Phone: Cell: Hom		
Preferred method of contact:		
Who may we thank for referring you?		
Your prior Doctor of Chiropractic and addre		
Chiropractic techniques you've had success	with:	
Last time you went to previous Doctor of Ch	niropractic	
General Practitioner, phone, city & state:	<i></i>	J
Please rate on a scale of 1 (poor) – 10 (exce	llent) the quality of healthcare you feel yo	ou receive from your GP:
Other specialists you are currently under ca	re with:	
Name:	Phor	ne:
Name:	Phor	ne:
Name:		
Occupation:	May v	we contact you at work Y N
Your employer, address and phone number	:/	J
Spouse's name:		Date of Birth//
Spouse's employer:()	Children's names &	ages: (
()	()	(
Favorite hobbies or interests:		
Method of payment for first visit: Cas	sh Check Credit Card	
Date of last menstrual cycle:/	/	
What do you understand chiropractic care t	o be?	
Do you know what a subluxation is? Y / N	if so, describe:	
What daily rituals for spinal health do you p	resently practice?	
On a scale of 1 to 10, with 10 being the high	nest, rate your commitment in helping us	solve this problem:

Do you have health (crisis care) insurance?  $\_\_\_Y \_\_\_N$ 

D.O.B	Acct #:
PATIENT APPLICATION FOR CAR	RE 2/5
Secondary Complaint (S)	Additional Complaint (A)
	The additional symptom that prompted
	me to seek care today is:
, 	
And are caused by: (darken circle)	And are caused by: (darken circle)
An accident or injury	An accident or injury
○ Work ○ Auto ○ Other:	○ Work ○ Auto ○ Other:
A worsening long term problem	A worsening long term problem
An interest in wellness	An interest in wellness
Other	o Other
	Onset (When did you first notice your current
	symptoms?)  Prior interventions (What have you done to
· · · · ·	relieve the symptoms?)
○ Prescription medication ○ Acupuncture	○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic	○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage	○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice	Physical therapy     Ice
	PATIENT APPLICATION FOR CAR  Secondary Complaint (S)  The secondary symptom that prompted me to seek care today is:  And are caused by: (darken circle)  An accident or injury  Work  Auto  Other:  A worsening long term problem  An interest in wellness  Other  Onset (When did you first notice your current symptoms?)  Prior interventions (What have you done to relieve the symptoms?)  Prescription medication  Acupuncture  Over-the-counter drugs  Chiropractic



Please rate the intensity of your primary complaint pain above.

Please indicate Pain (P)
Numbness (N), Tingling (T)

Have you had same or similar problem(s) before? Y / N How long ago?

What else should Dr. Bonner kno	w about your condition?	
Madication(a) various sussentiu taka	Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)
Medication(s) you currently take:	Tyreareation Tyanie	Boouge and Frequency (i.e. sing once a day, etc.)

Medication(s) you currently take:	Medication Name	Dosage and Frequency (i.e. 3mg once a day, etc.)
Check if NONE		
CHECK if more on back		
•		

Medication allergies:	Allergy to	Reaction	Additional Comments
vieuication anergies.			
Check if NONE			
CHECK if more on back			

My reason for consultation with	the Doctor is for evaluation of my physical health an	d the potential	for imp	rovement
Patient or Guardian Signature:_		Date:	_//	<b>'</b>



Name:	D.O.B.	Acct #:	

# **New Patient Application for Pregnant Patient**

		Date
Home Telephone	Work Telephone	
	Husband's Employ	
		Explain
Previous Major Illness or Su	irgery	
Medications you are current	ly taken or have taken since concep	otion
Allergies		<del>.</del>
	(If no did you ever smoke)?	
Do you drink? None	Social (Fewer then 2 daily)	Heavy (2 or more daily)
List the foods you eat daily a	and summary of your diet habits	
What type of exercises do yo	ou do?	
Age at last menstrual cycle?	Length of regular 1	menstrual cycle?
Are your cycles regular? Al	waysMost of the time_	Never
Date of your last menstrual of	cycleWas it norr	mal?
Date of last x-rays if any? _	Why and by whom	1?
Have you had any previous J	pregnancies? Explain	
Have you had past cesareans	s?How many?	
Have you had a previous D&	&C?How many and dates?	
Do you have any of the follo	owing?	
DiabetesAsthma	Rh negative bloodOtl	her chronic problems
Have you taken birth control	l pills?Type	
_	Date of removal	
Did you have any health pro		? Explain
=	opractic care?Dr's. Nam	ne
Who referred you to our offi	ice?	
Name of your obstetrician?	Nurse/Midwife?	
		e your baby?
	cy have you already experienced?	
<u>-</u>		



Name:	D.O.B.	Acct #:

## **PATIENT APPLICATION FOR CARE 3/5**

## **Systems Review**

It is important to read the following before filling out this form.

Any and all physical events that our body goes through leaves obvious and in most cases not so obvious findings. Therefore, it is important you take time and thoughtfully (as well as honestly) answer all the following questions. Even the ones you believe we have already verbally asked you.

#### 1. Review of Systems

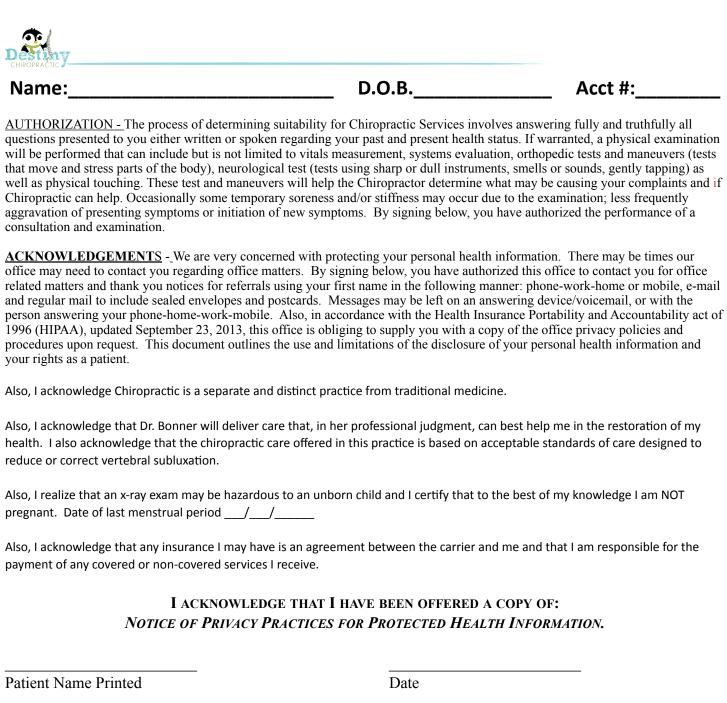
(Chiropractic focuses on the integrity of your nervous system which controls and regulates your entire body.

### Please circle any condition that you have had or currently have.

Musculoskeletal:	Respiratory:	hair loss
osteoporosis	Asthma	rash
arthritis	Apnea	tattoo(s)
scoliosis	Emphysema	body piercing(s)
neck trouble	hay fever	
mid back trouble	shortness of breath	Endocrine :
Low back trouble	pneumonia	thyroid issues
hip disorders		immune disorders
knee injuries	Digestive:	hypoglycemia
foot/ankle	anorexia/bulimia	frequent infections
shoulder/elbow/wrist	ulceri	swollen glands
TMJ	food sensitivities	low energy
poor posture	heartburn	
	constipation/diarrhea	Genitourinary:
Neurological:		kidney stones
anxiety	Sensory:	infertility
depression	blurred vision	bedwetting
headache	ringing in ears	prostate issues
dizziness	hearing loss	erectile dysfunction
tingling	chronic ear infections	PMS symptoms
numbness	loss of smell	
Cardiovascular:	loss of taste	Constitutional:
high blood pressure		fainting
low blood pressure	Skin:	low libido
poor circulation	skin cancer	poor appetite
angina	psoriasis	fatigue
excessive bruising	eczema	sudden weakness
high cholesterol	acne	weight loss/gain

<b>☆</b> /	
Dati	1 10
CHIROPRACTIC	у_

Name:		D.O.B	Acct #:	
	PATIENT APP	PLICATION FOR CARE 4	4/5	
AIDS Alcoholism Allergies arteriosclerosis cancer chicken pox diabetes epilepsy glaucoma goiter gout heart disease hepatitis	HIV positive malaria measles Multiple Sclerosis mumps polio Rheumatic Fever STD stroke tuberculosis Typhoid Fever ulcer other	3. Surgeries bypass surgery cancer cosmetic surgery elective surgery eye surgery hysterectomy pacemaker spine tonsilectomy vasectomy other	blood transfus chemotherapy chiropractic ca dialysis herbs/homeop inhaler massage thera physical theraj	ions , are pathy
5. <b>Injuries (have y</b>	ou ever had)			
had a fractured/b	roken bone			
had a spine or ne	ve disorder			
been knocked und	onscious			
been knocked und				
been injured in ar	accident			
been injured in ar	accident ther support			
been injured in ar	accident ther support			
been injured in ar used a crutch or c used neck or back	accident ther support bracing	it your health, hobbies and s	stress levels)	
been injured in ar used a crutch or c used neck or back Social History	accident ther support bracing (Tell Dr. Bonner abou	it your health, hobbies and s	·	○ no
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been injured in ar used a crutch or coused neck or back.  5. Social History Ilcohol use	ther support bracing  (Tell Dr. Bonner abou  (	Illnesses	Prayer/meditation?	ond no no no no no no no no no no no no no



Patient Name Printed	Date
Patient Signature	Authorized Provider Rep.
Personal Representative Printed	Personal Rep. Signature

Description of personal representative's authority to act for the patient