IDEAL SPINE
HEALTH CENTER

New Patient Application

Welcome to Our Clinic!

Welcome and thank you for applying as a patient to our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health even when many other systems may have failed. Due to the unique nature of our clinic, we may not accept you as a patient until we are certain that we know the cause of your condition and are able to establish an optimal rehab program specifically for you to help you recover your health. Please understand that if we accept you as a new patient, your health will need to be YOUR top priority as well as ours. At this point, specific recommendations will be tailored to your individual needs.

Thank you again for applying as a patient in our clinic.

Patient Signature: _____

Date: _____

NEW PATIENT APPLICATION

Full Name: _____Nickname :_____ Age _____Gender: [ ] M [ ] F
Home Street Address: _____ Home Phone: (____) _____
City, State, Zip:_____ Work Phone: (____) _____
Email Address: _____ Mobile Phone: (____) _____
Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W
Height_____ Weight_____ Race/Ethnicity: [ ] African American [ ] Arabic [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native Am.
Do you consider yourself to be: [ ] Normal Weight [ ] Underweight [ ] Overweight [ ] Obese [ ] Extremely Obese
Primary Spoken Language: _____ How were you referred to this office? _____
Occupation:_____ Employer Name: _____
Spouse's Name: _____ Spouse Work Phone: (___)_____ Spouse Mobile: (___) _____
Spouse's Employer: _____ Occupation: _____

PURPOSE OF VISIT

Reasons for appointment:	Date condition started:	Have you had this before?	Injury related?
1. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
2. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
3. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No

EXPERIENCE WITH STANDARD CHIROPRACTIC

Have you seen a Chiropractor before? [ ] Yes [ ] No Who? _____
When? _____ Reason for visits?_____
How did you respond? _____
Did your previous chiropractor take before and after **X-rays**? [ ] Yes [ ] No
Did your previous chiropractor tell you that **poor posture** can negatively affect your overall health? [ ] Yes [ ] No
Did your previous chiropractor make you aware of any of your **poor posture habits**? [ ] Yes [ ] No
Explain:_____
Are you aware of any poor posture habits in your **spouse or children**? [ ] Yes [ ] No
Explain:_____

OTHER PROVIDERS

Medical Doctors Seen:
Name:_____Date of last visit:_____ Is this your primary care provider? [ ] Yes [ ]No
Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No
Name:_____Date of last visit:_____ Is this your primary care provider? [ ] Yes [ ]No
Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No
Name:_____Date of last visit:_____ Is this your primary care provider? [ ] Yes [ ]No
Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Previous surgeries (all types) and dates: _____
_____
What other testing or treatments have you tried to date for **present condition** with location (facility) and dates of those tests and reatments:_____
_____
Current over-the-counter medications: _____
_____

Current prescription medications: _____

_____

_____

SOCIAL HISTORY AND LIFESTYLE

Do you exercise? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? [ ]Running [ ]Jogging [ ]Weight Training [ ]Cycling [ ]Yoga [ ]Pilates [ ]Swimming [ ]

Other_____

Do you consider yourself to be...? [ ] Underweight [ ] Normal weight [ ] Overweight [ ] Obese [ ] Severely obese

Do you smoke? [ ] Yes [ ] No How much? _____

Do you drink alcohol? [ ] Yes [ ] No How much? _____ per [ ] day [ ]week [ ] Month [ ] Year

Do you drink coffee? [ ] Yes [ ] No How many cups per day? _____

What supplements do you take (i.e. vitamins, minerals, herbs)? _____

FAMILY HEALTH HISTORY

Have any of your **biological family members** ever been diagnosed with the following:

[ ] Mental Health Disease	[ ] Neurological Problems	[ ] Lung Disease	[ ] Thyroid	[ ] Arthritis
[ ] Circulatory Problems	[ ] Immune System Problems	[ ] Heart Murmur	[ ] Back Pain	[ ] Cancer
[ ] High Blood Pressure	[ ] Heart Disease	[ ] Epilepsy	[ ] Stroke	[ ] Diabetes
[ ] Kidney Disease	[ ] Epilepsy/Seizures	[ ] Migraine Headaches	[ ] Osteoporosis	[ ] Scoliosis
[ ] Liver Disease	[ ] Infectious Disease	[ ] Gall Bladder	[ ] Broken Bones/Fractures	
[ ] Autoimmune Disorders	[ ] Digestive Disorders	[ ] Other: _____		

Family History	**Present Age(s)**	**Age(s) at Death**	**Medical Problems / Cause(s) of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

FOR OFFICE USE ONLY

Patient's Health Conditions Acceptable for Chiropractic BioPhysics® Corrective Care? [ ] YES [ ] NO [ ] Referred out:

_____

*Doctor's Signature:*_____ *Date:* _____