PURVIS CHIROPRACTIC CLINIC, PLC
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APPLICATION FOR NEW PATIENT STATUS

Date: _____ Referred by: _____ Case No. _____
(for office use only)

Name: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Employer: _____ Insurance Company: _____

Birthdate: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living With

Your SSN: _____ Spouse's Name: _____ Spouse's Occupation: _____

Number of Children: _____ Children's Name/Ages: _____

Past Chiropractic Care? ☐ Yes ☐ No When: _____ Chiropractor's Name: _____

Results: _____ Primary complaint: _____

Are your present injuries due to an on-the-job injury? ☐ Yes ☐ No
Have you made a report of your accident to your employer? ☐ Yes ☐ No
Do you plan on turning it in to Workman's Compensation? ☐ Yes ☐ No
Are you now or have you ever been disabled (service or work)? ☐ Yes ☐ No
If yes, when? _____ How? _____

ABOUT YOUR HEALTH

Please check any of the following symptoms and signs which you now have or have had within the last 6 MONTHS. An understanding of your health status will help facilitate care.

General Symptoms
☐ Headache
☐ Fever
☐ Chills
☐ Night Sweats
☐ Fainting
☐ Dizziness
☐ Convulsions
☐ Loss of Sleep
☐ Fatigue
☐ Nervousness
☐ Weight Loss
☐ Numbness/Pain in Limbs
☐ Allergy
☐ Wheezing
☐ Neuralgia

Skin
☐ Skin Eruptions
☐ Itching
☐ Dryness
☐ Eczema
☐ Hives/Allergy
☐ Sensitive Skin
☐ Boils
☐ Bruising

Muscles & Joints
☐ Weakness
☐ Twitching
☐ Stiff Neck
☐ Backache
☐ Swollen Joints
☐ Tremors
☐ Foot Trouble
☐ Painful Tailbone
☐ Pain between Shoulders
☐ Hernia
☐ Spinal Curvation
☐ Growing Pains
☐ Faulty Posture

For Women Only
☐ Painful Periods
☐ Excessive Flow
☐ Irregular Cycles
☐ Cramps & Backache
☐ Hot Flashes
☐ Vaginal Discharge
☐ Miscarriage
☐ Pregnant at this time?

Gastro-Intestinal
☐ Poor Appetite
☐ Poor Digestion
☐ Excessive Hunger
☐ Belching or Gas
☐ Nausea
☐ Vomiting
☐ Vomiting Blood
☐ Pain over Stomach
☐ Constipation
☐ Diarrhea
☐ Colon Trouble
☐ Hemorroids (piles)
☐ Liver Trouble
☐ Jaundice
☐ Gall Bladder Trouble

Genito-Urinary
☐ Frequent Urination
☐ Kidney Infection
☐ Bed Wetting
☐ Inability to Control Urine
☐ Prostate Trouble

Cardio-Vascular
☐ Rapid Heart Rate
☐ Slow Heart Rate
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pain over Heart
☐ Previous Heart Trouble
☐ Swelling of Ankles
☐ Poor Circulation
☐ Varicose Veins
☐ Heart Attack
☐ Strokes

Respiratory
☐ Difficulty Breathing
☐ Chronic Cough
☐ Spitting Phelgm
☐ Spitting Blood
☐ Chest Pain

Eye, Ear, Nose, Throat
☐ Poor Vision
☐ Crossed Eyes
☐ Pain in Eyes
☐ Deafness
☐ Earache
☐ Ear Noises
☐ Ear Discharge
☐ Nasal Obstruction
☐ Nose Bleed
☐ Sore Throat
☐ Hoarseness
☐ Hay Fever
☐ Asthma
☐ Frequent Colds
☐ Enlarged Thyroid
☐ Tonsilitis
☐ Sinus Trouble

HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES/CONDITIONS?

☐ Polio	☐ Flu	☐ Diabetes	☐ Tuberculosis	☐ Heart Disease
☐ Anemia	☐ Chorea	☐ Pleurisy	☐ Chickenpox	☐ Scarlet Fever
☐ Measles	☐ Lumbago	☐ Malaria	☐ Pneumonia	☐ Typhoid Fever
☐ Mumps	☐ Eczema	☐ Small Pox	☐ Rheumatism	☐ Rheumatic Fever
☐ Cancer	☐ Sciatica	☐ Appendicitis	☐ Diphtheria	☐ Whooping Cough
☐ Goiter	☐ Epilepsy	☐ Alcoholism	☐ Arthritis	☐ Venereal Infection
				☐ Mental Disorder

HAVE YOU EVER HAD ANY OF THE FOLLOWING OPERATIONS?

	Surgery date:		Surgery date:		Surgery date:		Surgery date:
☐ Tonsilectomy	_____	☐ Hernia	_____	☐ Thyroid	_____	☐ Female Organs	_____
☐ Appendectomy	_____	☐ Gall Bladder	_____	☐ Rectal Surgery	_____	☐ Back Surgery	_____

Other Operations: _____ Surgery date: _____

Accidents or Falls (childhood & adult): _____

_____

_____

Broken bones or dislocations: _____

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No _____

Were you ever knocked unconscious? ☐ Yes ☐ No _____

Have you ever had a lapse of memory ☐ Yes ☐ No When: _____

Have you ever had x-rays made of your case? ☐ Yes ☐ No If yes, by whom? _____

For what ailment(s) were these x-rays made? _____

Do you suffer from any condition(s) other than which you are now consulting us for? ☐ Yes ☐ No

If yes, please list the condition(s) _____

Are you presently taking any drugs/medication either prescribed or over-the-counter? ☐ Yes ☐ No

If yes, list drugs/medication: _____

AGREEMENT

PLEASE NOTE: It is understood and agreed that the amount paid to PURVIS CHIROPRACTIC CLINIC, PLC for x-rays is for examination and interpretation only. All x-ray negatives will remain the property of this office, remaining on file, where they may be seen at any time while a patient of this office.

I understand that all services are to be paid in full on the day of service unless other arrangements have been made and agreed on in writing.

_____ _____

Signature of patient or parent/guardian *Date*

I authorize the release of any medical information necessary.

_____ _____

Signature of patient or parent/guardian *Date*

I authorize payment of medical benefits to the PURVIS CHIROPRACTIC CLINIC, PLC

_____ _____

Signature of patient or parent/guardian *Date*