Vibrant Health Chiropractic
783 Route 3A ▪ Bow, NH 03304 • 603-856-7790 • www.vibranthealthchiropractic.org

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Patient Name_____ Today's Date_____

Address_____

City/State/Zip_____ Birthdate_____ Age_____

Cell/Home Phone (____) _____ Work _____ Ext_____

Email Address_____ Gender: ☐ Male ☐ Female ☐ Other

Occupation_____ Your Employer_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name _____Spouse's Employer_____

Emergency Contact Name_____ Ph_____

Children's Names & Ages _____

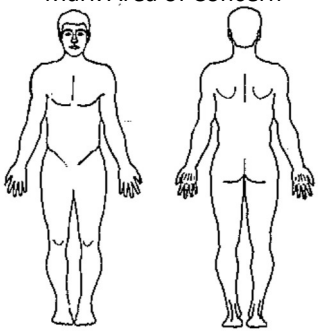
Prior Chiropractor_____ Last appointment_____

General Practitioner_____ City/State_____

Favorite Hobbies or Interests _____

Whom may we thank for referring you? _____

Mark Area of Concern



Health Reasons for Consulting Our Office:

1. _____ 3. _____

2. _____ 4. _____

Have you had similar problem(s) before? ☐ Yes ☐ No

Current Complaint (how you feel today): Please Circle

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

How often are your symptoms present?
(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant) How Long? _____

In the past week, how much has your pain interfered with your daily activities?
(ex: work, social activities, household chores) Please Circle

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unable to Perform anything)

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

Have you had any (circle all that apply) X-rays, MRI, CT scan for your area(s) of complaint? □ Yes □ No

Date Taken _____ What areas were taken? _____

Is this the result of an auto injury? □ Yes □ No Work Injury? □ Yes □ No

If so, when? _____

Other Doctors who have treated this problem. _____

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

Please check all of the following that apply to you.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)_____
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Osteoporosis
___Tobacco Use – Type_____Frequency_____/Day
___Cancer/Tumor (Explain)_____
___Surgeries_____
___Medications_____
___Other Health Problems (Explain)_____
___None of the Above

___Prostate Problems
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___Epilepsy/Seizures

What have you heard about chiropractic? _____

Do you know what a subluxation is? □ Yes □ No

If yes, please describe. _____

What daily rituals for spinal health do you presently practice? _____

Are you an active service member or first responder? □ Yes □ No Branch or Role: _____

Method of Payment for First Visit: □ Cash □ Check □ Credit Card

The above information is true and accurate to the best of knowledge. My reason for consultation with the doctor is for evaluation of the physical health and the potential for improvement.

Name: _____ Date: _____