RATCLIFF CHIROPRACTIC

NEW PATIENT APPLICATION

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

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____/_____/____ Age: ____ Last 4 of SSN: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Home _____ Work: _____ Cell: _____

Emergency Contact Name: _____ Phone: _____

Marital status: M/W/D/S Spouse's Name_____
Children's Name and Ages: _____

Your employer: _____
Occupation: _____
Employer's Phone number: _____ Address: _____

Who may we thank for referring you? _____
Please list any social media platforms you may have seen our practice on:
_____

Last time you went to a doctor of chiropractic _____
Your prior doctor of chiropractic and address: _____
Chiropractic techniques you've had success with: _____

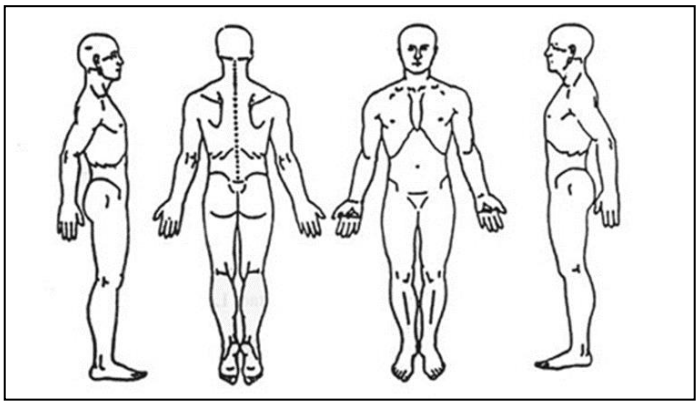
What have you heard about chiropractic care?
_____

Do you know what a subluxation is? If yes, please describe
_____

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

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 the result of an auto 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. _____

General practitioner: _____ City _____

Other Physicians you see on a regular basis: _____

Other doctors who have treated this problem: _____

Have you had any X-Rays, MRI's, CT scans for your area of complaint? Yes____ No ____
Date Taken and Facility: _____

Surgery you have had: _____

Medication(s) you currently take: _____

Do you have any medication allergies? _____

Is there any chance you are pregnant? Yes___ No___

Have you ever been diagnosed with cancer? _____
If so, what type? _____

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

Method of payment for today's visit: Check_____ Cash_____ Credit/Debit _____

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: ___/____/____
There is a $50 charge for New Patient Appointments not cancelled 24 hours prior to Apt.

Form updated 4/25/2022