

Innate Force Chiropractic

New Practice Member Application Form

Welcome to our Practice! In order to provide you the best possible wellness care, please thoroughly complete all questions and bring it to your first appointment. All information is strictly CONFIDENTIAL. Thank you.

Patient Data

First Name _____ Middle Initial _____ Last Name _____

M _____ F _____ Today's Date ____ / ____ / ____ Email* _____ @ _____

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Method of payment for first visit (If Necessary): Cash ___ Check ___ Credit Card ___

Personal Information

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Age _____ Birth Date ____ / ____ / ____ Social Security # _____ - _____ - _____

Who may we thank for referring you? _____

Occupation _____ Employer _____

Marital (circle) Mar. Wid. Div. Sin. # of Children _____ Spouse's Name _____

Emergency Contact _____ Phone _____

Health History

Previous Dr. of Chiropractic _____ Date of Last visit ____ / ____ / ____

General Practitioner Dr. _____ Phone _____

Other specialists whom you are currently under care with

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Ever been diagnosed with any of the following?

(Place an X) Diabetes ___ Hypertension ___ Cardiovascular Disease ___

Have you ever had a stroke? _____

Past Surgeries/Hospitalization (Please include dates)

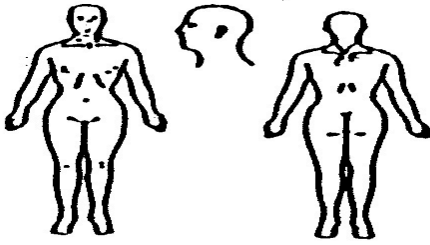
Past Fractured Bones (Please include dates) _____

Any known allergies? (Please List) _____

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Current Health Complaints

Mark areas of Health Concerns with an X



Please describe: _____

Date Symptoms 1st appeared ____ / ____ / ____

Currently are you? Better ____ Worse ____ Same ____

This the result of an: Activity Event Injury Auto Accident None of the Above

If yes, When? _____

Is this a recurring condition? Yes ____ No ____ If yes, last time this occurred? _____

Health reason(s)/concern(s) for consulting our office:

1. _____ 2. _____ 3. _____

Mother/Father/Siblings/Children with similar problems?

Are You Currently Taking Any Medications and/or Vitamins/Supplements?

(Please List) _____

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

What do you understand chiropractic care to be?

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

What (if any) daily rituals for spinal health do you presently practice?

Have you ever been diagnosed with cancer? Yes ____ No ____

If so, what type(s) & Diagnosis Date(s)? _____

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/Gaurdian Signature _____ Date ____ / ____ / ____