Treanor Chiropractic Wellness Center
NEW PATIENT APPLICATION

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

Name: _____ Date of Birth: ____/____/____
Address: _____ City/State/Zip:_____
Telephone: Home _____ Mobile _____ Work _____
Email Address:_____@_____
Preferred Method of Contact for Patient Reminders: Email / Phone / Text / Mail
Social Security #:_____ Marital Status: Married / Widow / Divorced / Separated / Single
Your Employer: _____ Occupation:_____
Employer's Address:_____
Spouse's Name:_____ Spouse's Date of Birth: ____/____/____
Spouse's Employer:_____ Spouse's Phone #:_____
Emergency Contact Name:_____ Phone#:_____ Relationship :_____
Children's Names & Ages:_____

Language(s):_____ Gender (Circle One) : Male or Female
Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Decline to Answer
Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)
Attach separate sheet if needed

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Tobacco Smoking Status: Current every day smoker ____ Current occasional smoker ____ Former smoker ____
Never smoked ____ Smoking start date _____ Smoking end date_____
Height _____ Weight _____
WOMEN ONLY: Is there any chance you are pregnant? Yes ___ No ___
Surgery you have had and when: _____
_____
Have you ever been diagnosed with cancer? _____ If so, what type?_____
Primary Physician: _____ Clinic Name & Location:_____
Your prior Doctor of Chiropractic & location: _____
Chiropractic techniques you've had success with: _____
Last time you went to previous Doctor of Chiropractic: _____

Continued on back page

Health reasons for consulting our office:

1._____ 3._____

2._____ 4._____

When did the current episode(s) begin? ____Today ____Days Ago ____Weeks Ago ____Months Ago ____ Years Ago

Have you had same or similar problem(s) before? ___Yes ___No

How long ago?_____ Please explain:_____

_____

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

_____

Is this the result of an auto or work injury? _____ If so, when? _____

Other doctors who have treated this problem: _____

What makes it feel better?_____

_____

What makes it feel worse?_____

_____

What activities is this keeping you from performing?_____

_____

What have you heard about chiropractic care?_____

_____

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

_____

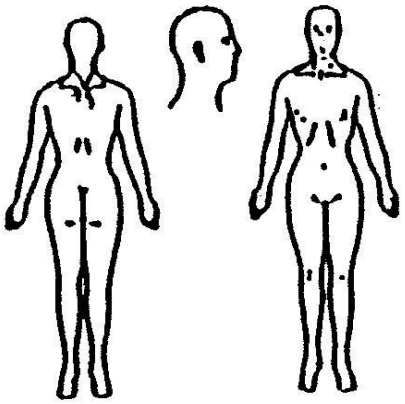
What daily rituals for spinal health do you presently practice?

_____

Favorite hobbies or interests:_____

_____

Please mark all areas of health concerns below



Who may we thank for referring you or how did you find out about us? _____

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

Method of payment for first visit (Required): _____Cash _____Check _____ Debit/ Credit ____HSA/HRA

I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed in writing. I understand that an interest charge may appear on all accounts over 90 days late. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. 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:____/____/____