New Patient Application

PATIENT INFORMATION

Date _____

Patient First Name _____
Patient Last Name _____
Address _____
City _____
State _____ Zip Code _____
Email _____
Best Phone Number _____
Sex ◯ M ◯ F Age _____ Birthdate _____
◯ Married ◯ Widowed ◯ Single ◯ Minor
◯ Divorced ◯ Partnered ◯ Separated

Employer/School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____

IN CASE OF EMERGENCY

Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you? _____

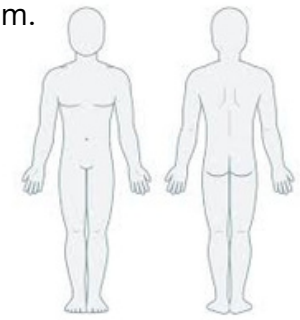
HOW CAN WE HELP YOU?

What brings you in today? _____

_____

How bad is it? How intense are your symptoms? 1 2 3 4 5 6 7 8 9 10

Please circle areas where you have pain or other symptoms. Use the body diagram.



What does it feel like? (Check all that apply.)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Aching
- ◯ Cramping
- ◯ Sharp
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Swelling

IMPACT OF YOUR SYMPTOMS

How is your health concern interfering with your life? (Check where appropriate.)

	Effect	No Effect		Effect	No Effect
Work	◯	◯	Energy	◯	◯
Exercise	◯	◯	Attitude	◯	◯
Recreation	◯	◯	Patience	◯	◯
Relationships	◯	◯	Productivity	◯	◯
Sleep	◯	◯	Creativity	◯	◯
Self-Care	◯	◯	Other _____	◯	◯

How committed are you to correcting this issue? 1 2 3 4 5 6 7 8 9 10

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CHILDREN AND PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns?

_____

_____

Are you currently pregnant?

○ No ○ Yes, I am due _____

Number of past pregnancies _____

Health concerns regarding your pregnancies?

_____

HEALTH AND ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ○ AIDS/HIV
- ○ Anxiety
- ○ Arterioschlerosis
- ○ Asthma/Allergies
- ○ Back Pain
- ○ Cardiovascular Issues
- ○ Cancer
- ○ Circulation Issues
- ○ Childhood Illness
- ○ Depression
- ○ Diabetes
- ○ Digestive Issues Constipation/Diarrhea/IBS
- ○ Elbow/Wrist/Hand Issues
- ○ Endocrine Issues (Thyroid)
- ○ Headaches/Migraines
- ○ Heart Disease
- ○ Hip Issues
- ○ Immune Issues
- ○ Lymphatic Issues
- ○ Multiple Sclerosis
- ○ Neck Pain
- ○ Osteoporosis
- ○ Reproductive Issues
- ○ Ringing in Ears
- ○ Scoliosis
- ○ Stroke
- ○ Urinary Issues
- ○ Other: (Please explain)

_____

_____

ALLERGIES, MEDICATIONS, & SUPPLEMENTS

ALLERGIES: (Please list)	MEDICATIONS: (Please list)	SUPPLEMENTS: (Please list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERRY FAMILY CHIROPRACTIC

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267.308.8197

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perryfamchiro@gmail.com

Tell Us About YOU!

For each category below, select all that apply.

Obstacles Hindering Health Goals

- ☐ Money
- ☐ Time
- ☐ Insurance Coverage
- ☐ Work
- ☐ Hobbies/Activities
- ☐ Doubtful/Skeptical
- ☐ Depression/Anxiety
- ☐ Difficulty Trusting
- ☐ Other: _____

What Are Your Daily Feelings?

- ☐ Irritable
- ☐ Low Energy
- ☐ Fog-Headed/Difficulty Concentrating
- ☐ Disconnected
- ☐ Overwhelmed
- ☐ Frustrated
- ☐ Concerned
- ☐ Powerless
- ☐ Other: _____

Activities You Avoid or Do Less of Because of Health Issues:

- ☐ Family Time
- ☐ Working
- ☐ Exercise
- ☐ Sleeping
- ☐ Hobbies/Interests
- ☐ Self-Care
- ☐ Eating Well
- ☐ Other: _____
- ☐ Explain: _____

What are your Obstacles to Resolving your Health Problems?

- ☐ Stress on Relationships or Job
- ☐ Spending Time or Money
- ☐ Fear It Will Not Improve
- ☐ Following in Footsteps of Parents
- ☐ Don't Know Where to Start
- ☐ Overwhelming
- ☐ Hopelessness/Power-lessness
- ☐ Given False Hopes
- ☐ Other: _____

Who Is Affected By or Sees You Suffering from Health Problems?

- ☐ Spouse
- ☐ Children
- ☐ Parents
- ☐ Friends
- ☐ Coworkers
- ☐ Boss
- ☐ Other Family Members
- ☐ Other: _____

How Do You Want to See Yourself?

- ☐ Strong
- ☐ Dependable
- ☐ Fun
- ☐ Connected
- ☐ Empowered
- ☐ Role Model
- ☐ Engaging
- ☐ Leader
- ☐ Nurturer
- ☐ Present
- ☐ Other: _____

What to Expect Next

- 30-minute complimentary consultation with Dr. Perry that includes:
  - How he may be able to help you
  - Answers to questions/concerns you have including finances, insurance, etc.
- 30-minute chiropractic analysis that includes:
  - In-depth detail on whether Dr. Perry can help you
  - Posture Check
  - Detailed Nerve Scan
  - X-rays (if necessary)
- Next Steps and an explanation of what they are after your chiropractic analysis

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