NEW PATIENT PAPERWORK

PERSONAL DATA

Today's Date: _____

Patient Name: _____

DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (Cell): _____ (Work): _____

Email Address: _____

Marital Status: S M D W L/W Name of Spouse: _____

Who May We Thank For Referring You? _____

☐ Yes, in addition to necessary doctor/patient communication, I would like to receive the Soul Chiro Community Email notifications about events and occasional specials/discounts! I understand that my email will never be given to an outside party.

REASON FOR SEEKING CHIROPRACTIC CARE

What brought you here today?

_____

In what ways do you feel our office can help you?

_____

Have you ever received chiropractic care? Yes ☐ No ☐ If yes, when? _____

_____

For how long and what was the frequency? _____

Why did you stop? _____

Does your immediate family, including kids, receive regular chiropractic care? Yes ☐ No ☐

WOMONE ONLY

Are your menstrual periods regular? Yes ☐ No ☐ If not, please describe: _____

_____

Do you currently or have you previously taken birth control? Yes ☐ No ☐

Reason: _____

Are you pregnant? Yes ☐ No ☐ If pregnant, due date? _____

Name of OBGYN/Midwife: _____

NEW PATIENT PAPERWORK

Stresses that affect the spine and nervous system may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the stresses that have acted upon your spine and nervous system assist us in serving you. With each of the following stress situations, please answer all that apply:

PHYSICAL STRESS

Please describe any major physical traumas and when they happened, including:

Accidents (adult or as a child)

Surgeries/Hospitalizations

Physical Stress at Work (sitting, lifting, etc.)

Physical Abuse

Major Dental Work (such as braces, etc.)

Other

EMOTIONAL STRESS

Please describe and give dates for any emotional stress related to:

Relationships

Work/School

Loss of Loved One

Childhood Trauma (parent's divorce, abuse, bullying, etc.)

ENVIRONMENTAL STRESS

List any drugs/medicines (past or current) and reasons for taking them. Including prescription/over-the-counter drugs:

Do you eat refined, processed foods? Please explain:

Do you:

Use Tobacco?	Yes ☐	No ☐	Consume Alcohol?	Yes ☐	No ☐
Use Illicit Drugs?	Yes ☐	No ☐	Consume Caffeine?	Yes ☐	No ☐

NEW PATIENT PAPERWORK

CURRENT LIFESTYLE

Have you consulted/do you consult with any of the following providers: (Circle all that apply)

Naturopath	Acupuncturist	Medical physician
Body work/massage	Psychotherapist	Dentist

Reason why:

Describe current diet:

Water Intake _____ Exercise _____ Sleep/Rest _____

Work Satisfaction _____ Family Dynamic _____

Do you have a spiritual/awareness practice? (meditation, yoga, prayer, etc.)

What is your ideal vision of yourself?

How is your present lifestyle affecting this vision of yourself?

What changes are you willing to make?

What is your number one priority in life?

When stressed, how do you “center yourself” or “regroup”?

What else would you like to share with us about yourself?

_____ _____

Signature of Patient Date Signed