

NEW PATIENT FORM

Welcome to Jonas Chiropractic! Please thoroughly complete all questions. Thank you.

Name: _____ Date: _____

Address: _____

City / State / Zip: _____

Phone: _____ Work: _____

Mobile: _____ Status: Married | Single | Divorced | Widow

Birthdate: ____ / ____ / ____ Age: ____ SSN # _____

Who may we thank for referring you? _____

Who was your prior Chiropractor: _____

Chiropractic techniques you've had success with: _____

Last time you went to the Chiropractor: _____

General Practitioner: _____

Location: _____

Place of Employment: _____

Work number: _____

Employer address: _____

Phone number: _____

Occupation: _____

Spouse's name: _____

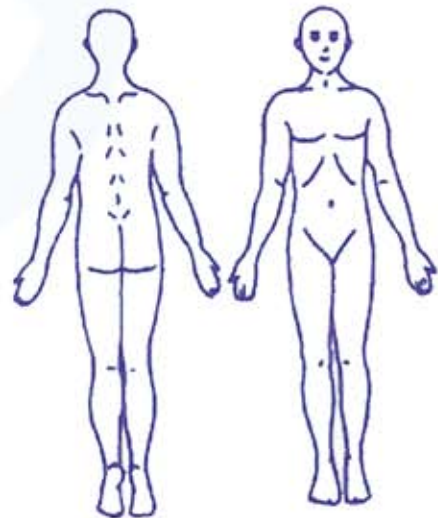
Spouse's employer: _____

Children's name & ages: _____

Favorite hobbies or interests: _____

Method of payment for visit: _____ Cash _____ Check _____ Credit Card

Mark area(s) of Health Concerns



Health reason for consulting our office:

1. _____ 2. _____

3. _____ 4. _____

Have you had same or similar problem(s) before? ___ Yes ___ No

How long?: _____

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 Workmen's Compensation Insurance requires you to see in the first 90 days?

If so, please list their name: _____

Other doctors who have treated this problem: _____

Surgery you have had: _____

Medication(s) you currently take: _____

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

What have you heard about chiropractic care?

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

What daily activities for spinal health do you presently practice?

Have you ever been diagnosed with cancer/heart disease? ___ If so, what type?

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

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: _____ / _____ / _____