MOTIVITY
CHIROPRACTIC

New Patient Application

Today's Date: _____/_____/_____ Appointment Reminders (please circle): Text / Email

How did you hear about us? ____________________

PATIENT INFORMATION

Legal Name: ____________________ Preferred Name: ____________________

DOB: _____/_____/_____ Age: ____________ ☐ Male ☐ Female

Address: ____________________

City: ____________________ State: ______________ Zip: ______________

E-mail Address: ____________________ Preferred Method of Contact: ____________________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

Employer: ____________________ Occupation: ____________________

Spouse's Name ____________________ Spouse's Employer: ____________________

No. of Children: ____________________ Ages: ____________________

Emergency Contact: ____________________ Phone: ____________ Relationship: ______________

Have you been to a chiropractor before? ☐ Yes ☐ No If yes, when? ____________________

Tell us one thing you do for fun/hobby: ____________________

INSURANCE INFO

Do you have insurance? ☐ Yes ☐ No Driver's License No.: ____________________

Primary insurance: ____________________ Policy #: ____________________

Policy holder's name: ____________________ Policy holder's DOB: ____________________

Covered dependents: ____________________

Secondary insurance: ____________________ Policy #: ____________________

Policy holder's name: ____________________ Policy holder's DOB: ____________________

Covered dependents: ____________________

WOMEN

Are you pregnant? ☐ Yes ☐ No ☐ Trying ☐ N/A

If so, how many weeks? ______________________

Date of your last menstruation: _____/_____/_____

Breastfeeding? ☐ Yes ☐ No

OBGYN: ______________________

Hospital: ______________________

Midwife: ______________________

Doula: ______________________

HEALTHCARE

Please list the names of your current healthcare professionals:

Primary Care: ______________________

Pediatrician: ______________________

Specialist: ______________________

Massage Therapist: ______________________

Please list current medications: ______________________

Please list current supplements: ______________________

PERSONAL CARE

How often do you exercise? For how long? ______________________

What activities do you do for exercise? ______________________

How much water do you drink each day? ______________________

How much do you sleep each night? ______________________

What activities (sitting, standing, lifting, etc)? does your typical workday include? ______________________

____

I eat: ☐ Very Healthy ☐ Pretty Healthy ☐ Like Crap

Please continue on to page 3

HISTORY OF COMPLAINT(S)

Please identify the problem(s) that brought you to us:

_____ I do not have any current complaints or concerns and seek Wellness/Maintenance/Preventative Care.

Please answer all questions as this will help us help you! *List your concerns in order of importance, and feel free to use the comments section at the end of each section if you need more room.*

PROBLEM 1

Concern: ______________________________ Severity: (0=no pain/10=unbearable) __________

When did this start? ______________________________

How did this happen? ______________________________

Getting better, worse, or same? ______________________________

Happened before? ____________________ Are symptoms constant or intermittent? ______________

Please list any activities that you are unable to perform or have trouble with because of this problem:

____

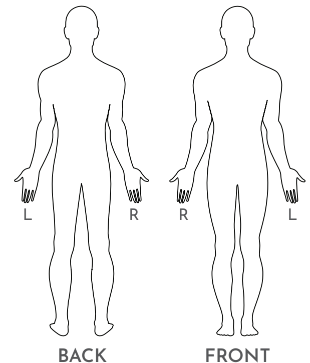
____

____

Please mark the areas on the diagram with the following letters to descibe your symptoms:

R = Radiating **B** = Burning **D** = Dull **T** = Tight

A = Aching **N** = Numbness **S** = Spasm



What relieves your symptoms? ______________________________

What makes your symptoms feel worse? ______________________________

____

Have you seen another provider for this condition? ☐ Yes ☐ No

If yes, who? ____________________ When? ____________________

Did it help? ______________________________

Have you seen a Chiropractor before? ☐ Yes ☐ No

If yes, who? ____________________ When? ____________________

Did it help? ______________________________

Extra comments: ______________________________

____

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____

PROBLEM 2

Concern: ______________________________ Severity: (0=no pain/10=unbearable) __________

When did this start? ______________________________

How did this happen?______________________________

Getting better, worse, or same?______________________________

Happened before? ____________________ Are symptoms constant or intermittent? ____________

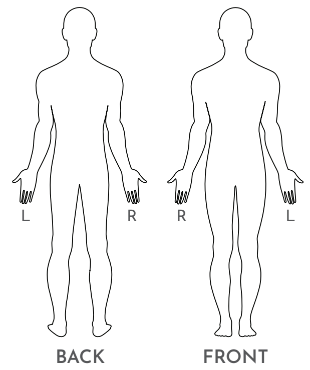
Please list any activities that you are unable to perform or have trouble with because of this problem:

____

____

____

Please mark the areas on the diagram with the following letters to descibe your symptoms:



R = Radiating **B** = Burning **D** = Dull **T** = Tight

A = Aching **N** = Numbness **S** = Spasm

What relieves your symptoms? ______________________________

What makes your symptoms feel worse? ______________________________

____

Have you seen another provider for this condition? ☐ Yes ☐ No

If yes, who? ____________________ When? ____________________

Did it help? ______________________________

Have you seen a Chiropractor before? ☐ Yes ☐ No

If yes, who? ____________________ When? ____________________

Did it help? ______________________________

Extra comments: ______________________________

____

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____

PROBLEM 3

Concern: ____________________ Severity: (0=no pain/10=unbearable) __________

When did this start? ____________________

How did this happen? ____________________

Getting better, worse, or same? ____________________

Happened before? ____________________ Are symptoms constant or intermittent? __________

Please list any activities that you are unable to perform or have trouble with because of this problem:

____

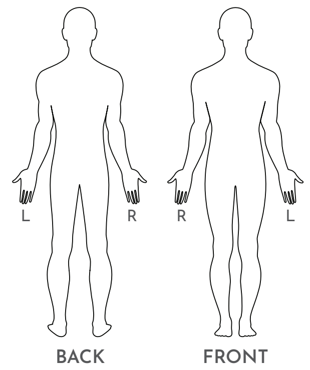
____

____

Please mark the areas on the diagram with the following letters to descibe your symptoms:

R = Radiating **B** = Burning **D** = Dull **T** = Tight

A = Aching **N** = Numbness **S** = Spasm



What relieves your symptoms? ____________________

What makes your symptoms feel worse? ____________________

____

Have you seen another provider for this condition? ☐ Yes ☐ No

If yes, who? ____________________ When? ____________________

Did it help? ____________________

Have you seen a Chiropractor before? ☐ Yes ☐ No

If yes, who? ____________________ When? ____________________

Did it help? ____________________

Extra comments: ____________________

____

____

____

PROBLEM 4

Concern: ______________________________ Severity: (0=no pain/10=unbearable) __________

When did this start? ______________________________

How did this happen? ______________________________

Getting better, worse, or same? ______________________________

Happened before? ______________ Are symptoms constant or intermittent? __________

Please list any activities that you are unable to perform or have trouble with because of this problem:

____

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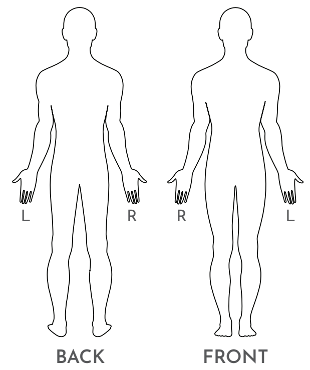

Please mark the areas on the diagram with the following letters to descibe your symptoms:

R = Radiating **B** = Burning **D** = Dull **T** = Tight
A = Aching **N** = Numbness **S** = Spasm

What relieves your symptoms? ______________________________

What makes your symptoms feel worse? ______________________________

____

Have you seen another provider for this condition? ☐ Yes ☐ No

If yes, who? ______________ When? ______________

Did it help? ______________________________

Have you seen a Chiropractor before? ☐ Yes ☐ No

If yes, who? ______________ When? ______________

Did it help? ______________________________

Extra comments: ______________________________

____

____

____

HEALTH HISTORY/ACCIDENTS

Please list any surgeries with dates: ______________________________

Please list any past serious accidents, traumas, or injuries: ______________________________

Please list any other medical condition(s) you have or had: ______________________________

Please list any allergies: ______________________________

Did/Do you have any of the following? (please circle)

Stroke   Cancer   Spinal Surgery   Spinal Fractures   Seizures   Heart Attack   Diabetes

Please mark "**P**" for Past symptom, "**C**" for Current symptom, "**N**" for Never a symptom:

____ Ear infections	____ Numb/Tingling in Legs/Feet	____ Stomach problems	____ Shoulder pain
____ Hearing Loss	____ Colic	____ High/Low Blood Pressure	____ Arm pain
____ Ringing in ears	____ Chest pain	____ Difficulty Breathing	____ Upper back pain
____ Dizziness	____ Heart problems	____ Allergies	____ Mid back pain
____ Loss of energy	____ Diabetes	____ Sinus issues	____ Broken bones
____ Nervousness	____ Dairy sensitivity	____ Frequent colds	____ Disc problems
____ Double/Blurry vision	____ Gluten sensitivity	____ Thyroid issues	____ Scoliosis
____ Anxiety	____ Nausea	____ Asthma	____ Poor posture
____ ADD/ADHD	____ Ulcers	____ Menstrual problems	____ Tight/sore muscles
____ Loss of Balance	____ Digestive issues	____ Infertility	____ Sports injury
____ Depression	____ Diarrhea	____ Sexual dysfunction	____ Lower back pain
____ Dyslexia	____ Constipation	____ Fibromyalgia	____ Hip/leg pain
____ Epilepsy/Convulsions	____ Bed wetting	____ Skin problems	____ Knee pain
____ Tremors	____ Kidney problems	____ Headache/Migraines	____ Foot pain
____ Sleep Problems	____ Bladder problems	____ Jaw/TMJ pain	____ Sciatica
____ Numb/Tingling in Arms/Hands	____ GERD/Gastric Reflux	____ Neck pain	____ Arthritis/joint pain

SOCIAL HISTORY

Tobacco:	Past	Daily	Weekends	Occasionally	Never
Recreational drugs:	Past	Daily	Weekends	Occasionally	Never
Alcohol:	Past	Daily	Weekends	Occasionally	Never
Caffeine:	Past	Daily	Weekends	Occasionally	Never

FAMILY HISTORY

Does anyone in your family have any health conditions? ☐ Yes ☐ No

If yes, who (mother, father, maternal/paternal grandmother/grandfather, etc.)? ______________________________

Condition(s): ______________________________

CONSENT

Person responsible for account (billing, appointment, and treatment information): ______________________________

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize staff to perform necessary services that I (or minor patient) may need during diagnosis and treatment with my informed consent.

I authorize payment to be made directly to Motivity Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I understand I am responsible for payment, including copayment and/or deductible, for services at the time they are rendered.

____ _______ / _______ / _______

Signature of Patient or Authorized Person for Account **Date**