

# GREATER LIFE FAMILY CHIROPRACTIC

## NEW MEMBER INFORMATION

Welcome to our office! Please complete all questions.

Name:	Date:	
Address:	City/State/ZIP:	
Home Phone:	Mobile Phone:	
Work Phone:		
Birth date:	Age:	Social Security #:
Marital Status:    S    M    D    W	Email:	
Your Employer:	Occupation:	
Spouse's Name:	Spouse's Employer:	
Children's Names and Ages:		
Favorite Hobbies or Interests:		
Method of Payment for First Visit: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Other _____		
Date of Last Adjustment:		
Who May We Thank for Referring You?		

**If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)**

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_
4. \_\_\_\_\_ For how long? \_\_\_\_\_

Do you ever experience any of these complaints while working?  Yes  No If yes, describe what activities at work that may be causing you to experience these complaints: \_\_\_\_\_

Have you had same or similar problem(s) before?  Yes  No If so, for how long? \_\_\_\_\_

Father, mother, brother, sister, children with similar problems?  Yes  No If so, who? \_\_\_\_\_

Other doctors you have seen for this problem: \_\_\_\_\_

Surgeries or hospitalizations you have had: \_\_\_\_\_

Medications you currently take:     Aspirin/Tylenol     Pain killers     Muscle Relaxers     Insulin     Tranquilizers

Birth Control Pills     Others \_\_\_\_\_

Have you been involved in an auto accident in the last 12 months?  Yes  No If yes, when? \_\_\_\_\_

Is there any chance you are pregnant?  Yes  No Have you ever been diagnosed with cancer?  Yes  No \_\_\_\_\_

Do you have health insurance? \_\_\_\_\_ Name of company: \_\_\_\_\_

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_