FEELGOOD CHIROPRACTIC

New Client Application

Name: _____ Date _____

Address: _____

Phone: _____ Email: _____

Date of Birth: _____ Children # & Ages: _____

Relationship Status: _____ Occupation: _____

How did you hear about us? _____

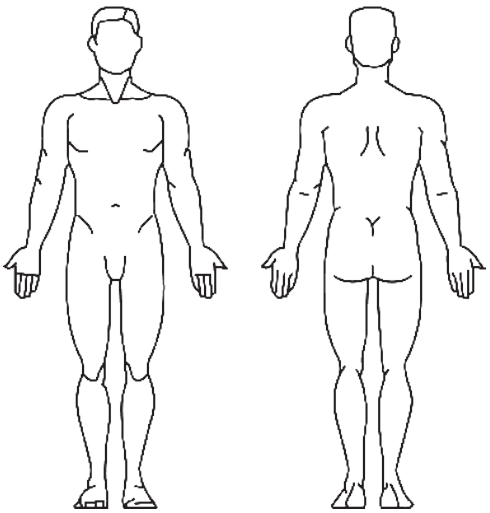
Major concerns: _____

Any previous treatment for this concern? _____ Have you had this before? ____

Please indicate your level of pain/discomfort (0 = no pain, 10 = extreme pain):

0	1	2	3	4	5	6	7	8	9	10

Please indicate the location of your pain or discomfort:



What words would you use to describe what you are feeling in relation to your complaint/s:

_____

_____

_____

_____

Any other concerns: _____

Please list any surgeries, injuries or motor vehicle accidents you've been in recently or in the past:

_____

Medications: _____

Physical activities: _____

Cancellation & No-Show Policy

Cancellations must be made at least 6 hours prior to your scheduled appointment. Otherwise a cancellation fee of 50% will be incurred. Thank you for your consideration and understanding.