NEW PT. ACCEPTANCE FORM

Name:______________________________DOB:________Age:____________

Contact Number☺______________________ ______________________

Insurance Carrier:____

Medications:______________________________Reason:________________

Check any Conditions and give Explanation

	ASTHMA	
	Bleeding Disorders	
	Blood Pressure	
	COPD	
	Diabetes	
	Ear/Sinus	
	Fainting	
	Gastro-intestinal	
	Heart Disease	
	Kidney Disease	
	Learning Disorders	
	Menstrual Problems	
	Musculo-skeletal	
	Psychological/Psychiatric	
	Seizures	
	Sickle Cell	
	Sleep Disorders	
	Stroke	
	Surgery	
	Thyroid Disease	
	Serious Inj.	
	Other	

Date:______________________________Signature:__________________________