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Patient Intake Form Date_____ File#_____

New Patient Information

First Name _____MI_____

Last Name _____

What You Prefer To Be Called_____

Street Address/Apt#_____

City/ State/ Zip_____

Email_____

Primary Phone_____

Secondary Phone_____

Date of Birth_____ Sex: _____

Gender/Preferred Pronouns: _____

Emergency Contact: _____

Relationship: _____

Emer. Contact Phone_____

How Did You Hear About Us?
(Circle One)
Walk-in Yelp Google Doctor Ins. Co. Patient

If Patient, Their Name_____

Employer_____

Occupation_____

Are We Billing Insurance for You: Yes No

If Yes, Ins. Co._____

Current Condition

The Reason for Today's Visit:

_____
_____
_____
_____

Have You Ever Been Under Chiropractic Care?

Yes No

If Yes, Please Explain:

_____
_____

If you are here for a specific condition/symptom, when did it begin?

_____
_____

Please describe your condition/symptoms:

_____
_____
_____

Constant: Yes No Getting Worse: Yes No

Getting Better: Yes No

How has your condition affected your overall health and well being?

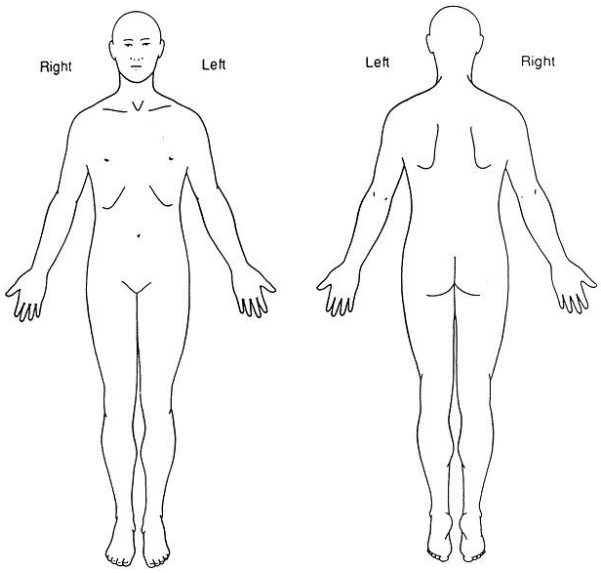
_____
_____
_____
_____
_____

Rate The Intensity Of Your Condition By Circling:

(Minor) 1 2 3 4 5 6 7 8 9 10 (Severe)

FORM CONTINUES ON THE BACK – PLEASE COMPLETE BOTH SIDES

Please Mark the Areas Involved With the Appropriate Symbols:
Burning= +++, Sharp Pain=XXX, Shooting Pain=!!!, Numbness=OOO, Stiffness=-----



Current Height_____ Weight_____

Do You Smoke Cigarettes: Yes No

How Much_____ How Long_____

How many glasses of water do you drink per day?

1 2 3 4 5 6 7 8 9 10 11 12+

Do you exercise or participate in other physical activities? Please describe:

_____

_____

_____

Pregnant: Yes No Nursing: Yes No

Medications_____

Vitamins & Supplements_____

Date Of Last Physical:_____

Health History

Allergies_____ Surgeries & Dates_____

Check Any Conditions That May Apply. Please Read Thoroughly:

__ALCOHOL/DRUG ABUSE
__ANKLE PAIN
__ARM PAIN
__ARTHRITIS
__ASTHMA
__BACK PAIN
__BROKEN BONES
__CANCER
__CHEST PAIN
__DEPRESSION/OTHER DISORDER
__DIABETES
__DIZZINESS
__ELBOW PAIN
__EPILEPSY
__EYE/VISION PROBLEMS
__FAINTING
__FATIGUE
__FOOT PAIN
__GENETIC SPINAL DISORDER
__HAND PAIN
__HEADACHES
__HEARING PROBLEMS
__HEPATITIS
__HIGH BLOOD PRESSURE
__HIP PAIN
__INSOMNIA
__JAW PAIN
__JOINT STIFFNESS
__KNEE PAIN
__LEG PAIN
__LOW BACK PAIN
__LOW BLOOD PRESSURE
__MENSTRUAL PROBLEMS
__MID BACK PAIN
__MINOR HEART TROUBLE
__MULTIPLE SCLEROSIS
__NECK PAIN
__NEUROLOGICAL DISORDER
__PACEMAKER
__PARKINSON'S
__POLIO
__PROSTATE PROBLEMS
__SHOULDER PAIN
__SIGNIFICANT WEIGHT CHANGE
__SINUS PROBLEMS
__SPINAL CORD INJURY
__SPRAIN/STRAIN
__STROKE/HEART ATTACK
__STOMACH PROBLEMS
__TUMOR
__ULCER(S)
__WRIST PAIN
OTHER/EXPLANATION_____
_____
_____
_____
_____

Do you or anyone in your immediate family have a history of any of the following:

Diabetes	Y	N	Who?_____
Cancer	Y	N	Who?_____ What kind?_____
High Blood Pressure	Y	N	Who?_____
Stroke	Y	N	Who?_____