OTT
CHIROPRACTIC NW

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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 received a massage or manual therapy before?

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?

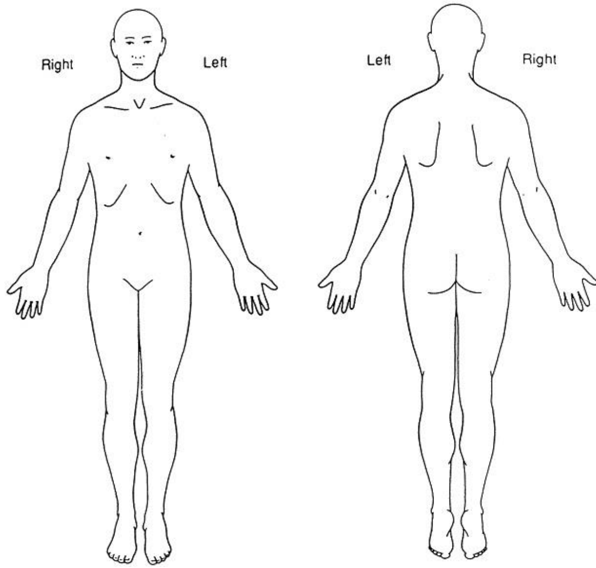
____
____
____
____
____

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:__________________________

What is your pressure preference during massage (circle one): Light Medium Hard/Deep

What type of music do you prefer during your massage:

- Yoga/Relaxing sounds
- Nature sounds
- Light Tunes with words
- Acoustic music without words
- No preference/Therapist choice