Welcome to our office! Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete, return it to our office with the bottom authorization checked and appropriate signatures filled in.

Personal Information

Contact Information

First Name: _____ Middle Name: _____ Last Name:

Gender: Female Male Date of Birth: _____ Height: _____ Weight: _____

Marital Status: M S D Spouse's Name: _____ Number of Children: _____

Home Phone _____ Cell Phone: _____ Work Phone: _____

Address: _____

City/State: _____ Zip/Postal Code: _____

*Email:_____

(We will NOT share your email with any third party. We will use your email to contact you regarding your care with our practice.)

Emergency Contact: _____ Relationship: Phone:

Employment Information

Occupation: _____ Regular Work Status: _____

Employer Name: _____

Employer Address: _____

Employer City/State/Zip: _____

How did you find out about our office? _____

Referring Physician Name: _____

Referred by: _____

What is the purpose of your visit? (circle one)

Wellness Pain/Complaint Injury Other: _____

Where did the injury occur? (circle one)

Automobile Work 3rd Party Premises Other: _____

Insurance & Payment for Care

How do you plan to pay for care?

Personal Insurance Third-Party Insurance No Insurance Self-Pay

Name of Party Responsible for Payment: _____

Responsible Party Phone: _____

Insurance Information:

Insured's Name: _____ Insured's Date of Birth: _____

Primary Insurance Name: _____

Phone: _____

Address: _____

City/State/Zip: _____

ID/Policy #: _____ Group #: _____

Secondary Insurance Name: _____

Phone: _____

Address: _____

City/State/Zip: _____

If an auto accident, please provide:

Claim #: _____

Insurance Contact Person: _____

Insurance Phone: _____

Attorney's Full Name: _____

Attorney's Phone: _____

What is/are your chief complaint(s) (list in order of importance)**:** _____

_____

Date of Injury/When did pain begin: _____

Please describe how the injury, pain, or discomfort originated: _____

_____

Please describe what your pain/discomfort feels like: _____

Select frequency you experience pain from this condition: Always Hourly Daily Occasionally

Has this concern: Gotten Worse Stayed Constant Come and Gone

Does this condition interfere with any of your daily activities or routines?

No Yes If yes, Explain: _____

Has this condition affected your quality of sleep or ability to sleep?

No Yes If yes, Explain: _____

Has this condition affected your appetite?

No Yes If Yes, Explain: _____

Have you missed any work/reduced hours due to this injury?

No Yes If Yes, Explain: _____

Is the pain/discomfort worse at certain times of the day?

No Yes If Yes, Explain: _____

Does the weather affect your pain/discomfort?

No Yes If Yes, Explain: _____

Has this condition interfered with your workouts or exercise routine?

No Yes If Yes, Explain: _____

List anything that makes your condition worse: _____

_____

List anything that relieves or improves your condition: _____

_____

Have you received professional treatment for this condition?

No Yes If Yes, From whom/did it help?:

Have you had X-rays taken for this condition?

No Yes If Yes, Where/When?:

Pain level Rating - Scale 1 to 10 (Where 1 is least pain and 10 is maximum pain)

At its best: At its Worst: Current Level:

What are your overall goals you'd like to accomplish from your visit (circle all that apply):

Pain Relief Movement Assessment Wellness/Healthy Lifestyle Exercise Evaluation Other

_____

Please explain your specific goals for our office:

_____

_____

_____

_____

Are you interested in learning about any of the following (circle all that apply):

Exercise tips	Nutrition	Supplements	Home Care
Natural Lifestyle	Wellness	Emotional Health	Chemical Health
Physical Health	Orthotics	Training/Routine	Other _____

Personal Health History

Family/Primary Physician Name:_____ Date of Last Physical Exam: _____

Physician Phone: _____

Physician Address: _____

Physician City/State/Zip: _____

Please list any health conditions that you have been treated for in the last year: (condition, cause, current/resolved) _____

_____

_____

Have you had previous chiropractic care? No Yes Was it a good experience? Explain:

If Yes, Condition(s) treated: _____

Date of last chiropractic visit: _____

Are you pregnant, or have you had any signs of pregnancy? (Female Only)

No Yes

Are you planning to get pregnant in the next 12 months? (Female Only)

No Yes

List current medications: (name, amounts, frequency, length of use, reason for use) _____

_____

List current vitamins, minerals, supplements, or herbs: (name, amounts, frequency, length of use, reason for use) _____

_____

Personal Incident History:

History of Broken Bones?

No Yes If Yes, Explain: _____

_____

Had Major Sprains/Strains?

No Yes If yes: Did you get professional care/treatment? No Yes

Have you ever been Hospitalized?

No Yes Briefly Explain: _____

Had Surgery?

No Yes Briefly Explain: _____

Been In Auto Accident?

No Yes If yes: Did you get professional care/treatment? No Yes

Briefly Explain: _____

Been Struck Unconscious?

No Yes If yes: Did you get professional care/treatment? No Yes

Briefly Explain: _____

Been Diagnosed with an Eating Disorder?

No Yes If Yes, Briefly Explain: _____

Had a Stroke?

No Yes If Yes, Briefly Explain: _____

Family Health History

Please list diagnosed health conditions and untimely deaths that have occurred to immediate family members (Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.): *Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles*

Social History & Life Choices:

Alcohol: Daily Weekly Occasionally Never

Caffeine Drinks & Products: Daily Weekly Occasionally Never

Diet Food Products: Daily Weekly Occasionally Never

Drugs: Daily Weekly Occasionally Never

Energy Products or Over-the-Counter Stimulants: Daily Weekly Occasionally Never

Exercise: Daily Weekly Occasionally Never

Briefly explain type/style of exercise: _____

Fresh & Homemade Foods: Daily Weekly Occasionally Never

Preprocessed, Packaged, & Restaurant Food: Daily Weekly Occasionally Never

Soft Drinks: Daily Weekly Occasionally Never

Tobacco: Daily Weekly Occasionally Never

If Yes, how many packs/day: _____

If No, Have you ever used Tobacco? Yes No If Yes, When did you quit: _____

Water: Daily Weekly Occasionally Never

Please circle all that you have had or currently have:

Allergies	Alcoholism	Dizziness	Epilepsy
Pacemaker	Parkinson's	Anemia	Arteriosclerosis
Arthritis	Asthma	Autoimmune Disease	Bleeding disorder
Gout	Kidney Disease	Memory Loss	Concussion
Cancer	Fatigue	Bronchitis	Loss of taste/smell
Bruise Easily	Cancer	Cataracts	Glaucoma
Heart Disease	Heart Attack	Stroke/TIA	Chest Pain
High Blood pressure	Cold extremities	Bowel/Bladder disorder	High Cholesterol
COPD/emphysema	Cramps	Headaches/Migraines	Infectious Disease
Dementia/Alzheimer's	Depression	Diabetes	Digestive Problems
Dizziness	Loss of Balance	Skin Rash	Insomnia
Thyroid Disease	Vision Changes	Poor Posture	Extremity Pain
Menopause	Shortness of Breath	Varicose Veins	Blood Clot
Arthritis	Seizures	Diabetes	Osteo-penia/porosis
Scoliosis	Weakness	Numbness/tingling	Other

If Other, please explain: _____

_____

Have you had any of these Cardiovascular Diseases? Yes No Please select all that apply:

Myocardial infarction Hypertension Hypercholesterolemia Bypass surgery Other

Authorization:

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

By signing below, I agree with this statement of authorization

Patient Name (Please Print): _____

Signature: _____

*Parent/Guardian Name (Please Print): _____

*Parent/Guardian Signature: _____

(*A parent/guardian's signature is needed if the patient is under the age of 18 and/or cannot legally sign for him/her-self)