PATIENT INTAKE FORM

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ SSN: _____

Cell: _____ Which number do you prefer to be reached at? (Circle): Hm / Wk / Cell

Emergency Contact Name and Phone Number: _____

Who/what referred you to our office? _____

We periodically send email updates on health issues, lifestyle tips, etc. If you do **NOT** want these, check here: _____
Email: _____

Age: _____ Date of Birth: _____ Gender: (M) _ (F) _ Height _____Weight _____

Occupation: _____ Employer: _____

Marital Status (circle one): Single / Partnered / Married / Divorced / Separated / Widowed

Partner's Name (if applicable): _____ # of Children: _____

Do you have a family history of: (circle) Cancer / Diabetes / Heart / Blood Pressure / Other serious illness:

_____

What is your primary unwanted health condition, or the reason you are here? _____

_____

How and when did the condition begin? _____

Have you previously received chiropractic care? Y _ N __ If yes, when? _____

(Women) Are you pregnant? YES NO Uncertain

Please list any prescription or over-the-counter medications you are currently taking: _____

_____

Please list any vitamins, supplements, herbs, or homeopathies you are currently taking: _____

_____

Are there any other additional questions or concerns that you'd like to discuss? _____

_____

What is your commitment level to improve your health? _____ %

What are your goals and how will you measure the success of your care under them? _____

What can we do to make you happier? _____