

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our **Patient Intake Form**. Please fill this form out 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.

Patient Information

*First Name: _____ Middle Name: _____ *Last Name: _____
Birth day: _____ Height: _____ Weight: _____
Sex: M F Home #: _____ Cell #: _____
Married/Civil Union: Married Single Spouse Name: _____ # of Children: _____
Address: _____
City: _____ State: _____ Zip: _____
*Email: _____

Employer Information

Employed: Full Time Part Time Homemaker Unemployed Employer Name: _____
Employer Address: _____
Employer City: _____ Employer State: _____ Employer Zip: _____
Occupation: _____ Work Supervisor: _____ Supervisor #: _____
Physical Work Duties: _____

History

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)

Have you Ever:

Broken Bones: Yes No Treatment: Yes No Explain: _____
Sprains/Strains: Yes No Treatment: Yes No Explain: _____
Hospitalized: Yes No Explain: _____
Surgery: Yes No Explain: _____
Auto Accident: Yes No Treatment: Yes No Explain: _____
Struck Unconscious: Yes No Treatment: Yes No Explain: _____
Eating Disorder: Yes No Explain: _____
Stroke: Yes No Explain: _____
Family Health History: _____

Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.

Social History & Life Choices

Alcohol: Daily Weekly Occasionally Never
Diet Food Products: Daily Weekly Occasionally Never
OTC Stimulants: Daily Weekly Occasionally Never
Homemade Food: Daily Weekly Occasionally Never
Soft Drinks: Daily Weekly Occasionally Never
Water: Daily Weekly Occasionally Never
Caffeine Drinks: Daily Weekly Occasionally Never
Drugs: Daily Weekly Occasionally Never
Exercise: Daily Weekly Occasionally Never
Processed Food: Daily Weekly Occasionally Never
Tobacco: Daily Weekly Occasionally Never

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? Newspaper Sign Facebook Yelp Community Event Mailing

Have you been adjusted by a chiropractor before? Yes No

If yes, what was the reason? _____

Doctor's Name: _____ Date of last visit: _____

Has any member of your family seen a wellness chiropractor? Yes No

Reason for this Visit

Describe the reason for this visit: _____

Impact on Life: _____

(Skip this section for wellness services)

When did this concern begin? _____

Has this concern? Gotten worse Stayed Constant Come and Gone

Does this concern interfere with: Work Sleep Daily Routine Other Activities

Briefly explain: _____

Has this concern occurred before? Yes No Briefly Explain: _____

Have you seen other doctors for this concern? Yes No Doctor's Name: _____

Type of Treatment: _____

Results: Good Bad Indifferent

Women Only

Are you pregnant? Yes No

Are you taking birth control? Yes No

Do you have irregular cycles? Yes No

Do you have breast implants? Yes No

Are you nursing? Yes No

Do you experience painful periods? Yes No

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

I want the Doctor to select the type of care for my condition.

Relief Care: Symptomatic relief of pain or discomfort.

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

Were you aware that...

Doctors of Chiropractic work with the nervous system?

Yes No

The nervous system controls all bodily functions and systems?

Yes No

Chiropractic is the largest natural healing profession in the world?

Yes No

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 the office of chiropractic.

I authorize this office and its staff to examine and care for me as the doctors see fit. 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.

I agree with this statement of authorization *

Printed Name: _____

Patient/Guardian's signature: _____

Date: _____