

**Patient Intake Form**

Full Name: Date:

First MI Last

Address: City: State: Zip:

Age: Date of Birth (DOB): Gender:

Social Security Number: Email Address:

Home Phone: Work Phone: Cell/Other:

Employer: Occupation:

Preferred Language: (Circle One) English / Spanish / French / Other:

Race: (Circle One) American Indian or Alaska Native / Asian / Black or African American / White or Caucasian /

Hispanic or Latina / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Current marital status: Single / Married / Separated / Divorced / Widowed / Minor

Insurance Information

Policy Holder / Relationship to Patient: Policy Holder’s Date of Birth:

Emergency Contact / Relationship to Patient:

Emergency Contact Phone Number:

Do you use tobacco products? □ Yes □ No packs / cans per . How many years?

Do you drink alcoholic beverages? □ Yes □ No drinks per day.

Do you exercise? □ Yes □ No Hours/ week? Activities?

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks?

Allergies (Medications, foods, animals, …etc) and reaction:

Current Medication/Supplement List:

|  |  |  |  |
| --- | --- | --- | --- |
| Name / Condition Treated | Dose / Frequency | Name / Condition Treated | Dose / Frequency |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Family History (list all major diseases (such as cancer, diabetes, heart problems, bone/joint diseases) of blood relatives, the

Individuals relation to you, and whether they are alive or deceased):

Past Medical Procedures / Surgeries:

|  |  |  |  |
| --- | --- | --- | --- |
| Procedure | Date (Month and Year) | Procedure | Date (Month and Year) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? What type?

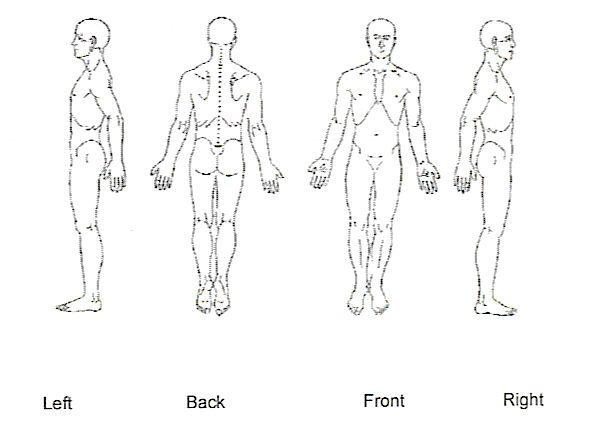
When did your symptoms start? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** How did your symptoms begin? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How often do you experience symptoms? (Circle one)Constantly Frequently Occasionally Intermittently

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?

On a scale of 1-10, please circle how intense your symptoms are: Not intense 🄋➀➁➂➃➄➅➆➇➈➉ Unbearable

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning

T = Tingling S = Stiffness O = Other

**For the conditions above, please indicate if you have had the**

**condition in the past or if you presently have the condition.**

Name and Clinic of Previous Chiropractor: Date of last treatment:

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

Primary Care Physician/Clinic:

Address: Phone: Date last seen: