

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 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: _____	SSN: _____	Birthday: _____
Sex: <input type="radio"/> M <input type="radio"/> F	Middle Name: _____	*Last Name: _____
Married/Civil Union: <input type="radio"/> Married <input type="radio"/> Single	Height: _____	Weight: _____
Home #: _____	Spouse Name: _____	# of Children: _____
Address: _____	Cell #: _____	Work #: _____
City: _____	State: _____	Zip: _____
*Email: _____		

Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> 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: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Sprains/Strains: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Hospitalized: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Surgery: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Auto Accident: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Struck Unconscious: <input type="radio"/> Yes <input type="radio"/> No	Treatment: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Eating Disorder: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	
Stroke: <input type="radio"/> Yes <input type="radio"/> No	Explain: _____	

Family Health History: _____

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

Social History & Life Choices

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never	Caffeine Drinks	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Diet Food Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never	Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
OTC Stimulants:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never	Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Homemade Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never	Processed Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never	Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never					

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? Newspaper Sign Yellow Pages 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 ever 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)

Wellness Sports Auto Fall Home Injury Job Chronic Discomfort Other

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

Are you nursing? Yes No **Do you experience painful periods?** Yes No **Do you have breast implants?** 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 appropriate 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 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.

I agree with this statement of authorization *

Name of the Insured :

Patient Signature: _____

Date: _____