

# 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? \_\_\_\_\_