

CHIROPRACTIC INTAKE FORM

Patient Name: _____ Date of Birth: _____

Contact Information:

Address: _____

City, State, Zip: _____

Phone Number: _____ Email: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information:

Primary Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Reason for Visit:

Please describe your primary reason for seeking chiropractic care:

Health History:

Have you ever been treated by a chiropractor before?

Do you currently have or have you had any of the following? (Check all that apply)

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Other (please specify): |

Medications:

Please list any medications you are currently taking:

Allergies:

Please list any allergies you have (medications, foods, environmental):

Lifestyle:

Do you smoke? Yes No

Do you consume alcohol? Yes No

Do you exercise regularly? Yes No

What is your occupation? _____

Consent and Authorization:

I hereby authorize the doctor and whomever they may designate as their assistant to administer chiropractic care as they deem necessary to me. I acknowledge that no guarantees have been made to me regarding the results of treatment or examination. I understand that chiropractic treatment involves manual therapy including spinal manipulation and other procedures and that there may be some risks including, but not limited to, muscle soreness, aggravation of pre-existing symptoms, strokes, or other complications. I certify that the above information is true and correct to the best of my knowledge, and I agree to notify the doctor of any changes in my health status. I understand that I am responsible for all charges incurred for services rendered.

Patient Signature

Practitioner Signature

Date: _____

Date: _____

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