Patient Intake Information

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction

☐ Check here if you want the doctor to select the type of care he feels best for you. Date ________________

Name: ____________________________________ S/S#____________________ Date of Birth:__________

Address:____________________________________ City: ___________________ State:____ Zip Code:___________

Home Phone Number:_________________________ Cell Phone:______________ Work Phone: _________________

Email: ____________________________ Check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Your Employer: _________________________________ Your days off: ______________________________

Name of Husband/Wife: ________________________ Spouse Employer: ______________________________

Emergency Contact (if different from spouse): ____

Referred to our office by: _________________________________

Who is responsible for the bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other

How will payment be made? ☐ Cash ☐ Check ☐ Credit Card ☐ Workers Comp ☐ Auto Ins

If you are in pain please mark the exact location on the diagram below

Left Right

Right Left

Major Complaint

Please describe only your major problem.

____

____

____

____

____

____

____

____

____

How did this condition develop? (What caused it? How did it start?) ___________________________________

____

____

When were you first aware of this problem? ____

Have you ever had this problem before? If yes, please explain ______________________________________

____

Have you ever received treatment for this condition? If yes, where, when, and what were the results? ______________

____

Has this problem been getting better, worse, or staying the same? ____________________________________

Please complete the other side

Is there anything that makes your condition worse? ____

____

How has this condition affected your life?

A. Home life ____

B. Occupational life ____

C. Recreational life ____

D. Rest and Sleep ____

Have you ever been in an automobile accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

ANY ACCIDENTS, FALLS, ETC. THAT MIGHT HAVE CAUSED YOUR PROBLEM ________________________

____

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT ____

____

List all surgeries: ____

____

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐Muscle Relaxers ☐ "Pep" Pills ☐Tranquilizers ☐ Insulin ☐ Birth Control ☐ Other ____

ANY CHIROPRACTOR CONSULTED IN THE PAST: Name ______________________ Town ____________

Date consulted: _________________________ For what problem: _________________________________

I certify that I have read and understand the above Case History questions. The Case History questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I give my consent to be examined and treated. I agree to be financially responsible for my care.

____

Signature of Patient (or parent if a minor) Date

For Doctor Use