NEW PATIENT INTAKE FORM

WELCOME TO OUR PRACTICE! PLEASE TELL US ABOUT YOURSELF:

Today's Date _____/_____/ _____ **Patient #_____**

Full Legal Name _____

Male ___ Female ___ Single___ Married___ Widow___ Divorced___ Spouse/Partners name_____

How you prefer to be addressed _____ Birthdate _____/_____/_____ Age_____

Cell Phone # _____-_____-_____ Cell phone service carrier _____

Street Address _____ EMAIL: _____

City _____ State _____ Zip Code _____

Employer's Name _____ What do you do there? _____

Retired _____ What type of work did you perform? _____

How did you learn about our office? _____

In Case of Emergency Contact _____ Phone # _____-_____-_____ Relationship _____

Is your current condition the result of an accident/injury? Yes __ No ___ If yes: Auto __ Work __ Slip/Fall __

List your current symptoms? 1. _____ 2. _____
3. _____ 4. _____

What level of intensity would you rate your pain? (10 = severe) ***1 2 3 4 5 6 7 8 9 10***

What is the frequency of your symptoms? ***Occasional / Episodic / Intermittent / Frequent / Constant***

Do your symptoms affect your personal life or job? (sleep, hobbies, sports, missed days, inability to stand, sit, lift, drive)

_____

_____

_____

Have you suffered from these symptoms before? □ Yes □ No **When did these symptoms start _____**

What makes your symptoms worse?_____

What makes your symptoms feel better?_____

Have you been to any other type of doctor for this problem? _____

Have you been to a Chiropractor before? □ Yes □ No If Yes, name:_____

Did prior chiropractic treatment help your problem?_____

Do you have a primary care physician?____ If yes, name: _____

***Attention Medicare patients: We are required to bill Medicare for your treatment and they should reimburse you directly. If you have additional coverage Medicare will forward the covered charges to your secondary insurance. Please note we are not in network with any Medicare Advantage Plans. Payment is due at the time of service.**

2/1/2023