PATIENT INTAKE FORM

LAST NAME_____**FIRST NAME**_____**MIDDLE**_____
ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____
S.S.#_____ **BIRTHDATE**_____**AGE**_____**# OF CHILDREN**_____
HOME #_____ **WORK #**_____**CELL #**_____
E-mail _____
EMPLOYER_____ **SPOUSE**_____ **REFERRED BY**_____

Primary Care Physician _____ **Address & Phone** _____

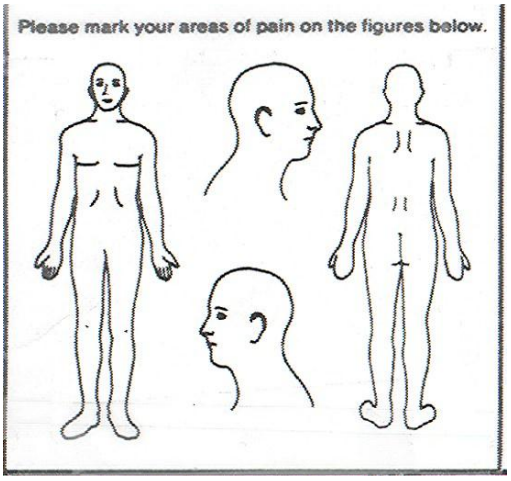
Primary insurance co. _____ **ID#** _____ **Group#** _____
Is there a secondary insurance YES/NO
Secondary insurance co. _____ **ID#** _____ **Group#** _____

INSURED'S INFORMATION (If other than patient)
Policy Holder_____ **Employer** _____**S.S.#**_____
Birthdate _____ **Relationship to insured**_____

What is your major complaint?_____
_____
Other complaints?_____

How long have you had this condition?_____**Have you had this or a similar condition in the past?**_____
Did your condition occur while at work?_____ **Do you ever experience this pain while at work?**_____

Is there anything outside work that could have caused this injury?_____
Is this condition getting progressively worse? ___Yes ___No ___Constant ___Intermittent



___Neck Problems	___Sore Muscles	___Allergies
___Shoulder Problems	___Walking Problems	___Hay Fever
___Arm Problems	___Broken Bones	___Asthma
___Numbness-Arms	___Muscle Cramps	___Eczema
___Pain between Shoulders	___Weak Muscles	___Shingles
___Low Back Problems	___Headaches	___Nausea
___Leg Problems	___Dizziness	___Poor Digestion
___Numbness-Legs	___Fainting	___Ulcers
___Loss of Feeling	___Forgetfulness	___Diarrhea
___Stiff Joints	___Depression	___Constipation
___Painful Joints	___Vision Problems	___Kidney Infection
___Restricts Daily Activities	___Ear Infections	___Diabetes
___Restricts Exercise	___Frequent Colds	___Blood Pressure
___Tiredness/Fatigue	___Hearing Loss	___Ear Pain/ Noise

This is a *new/old* illness. It *was/was not* treated
If treated before, what was done?_____
_____
Name of Doctors:_____
Have you ever had surgery or been hospitalized?
__Yes __No List Surgeries_____
_____
Have you ever had Chiropractic care before?_____
Name of Doctor_____**Date**_____
Last time you had spinal x-rays:_____
Medications you now take:_____
_____
1)Car accidents_____
_____
2)Falls/Injuries_____
_____

SIGN & DATE:_____

History/Consultation