



Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

Driver's License#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed Number of Children: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Have you previously had Chiropractic Care? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Did it help? \_\_\_\_\_

List your chief complaints in order of severity:

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_

Please describe work activities that may be causing your complaint \_\_\_\_\_

Please explain any other activities outside of work, which may have caused these complaints? \_\_\_\_\_

If this is due to an injury or accident, when did it happen? \_\_\_\_\_

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

What activities make your condition worse? \_\_\_\_\_

Have you been involved in an auto accident in the last 12 months? \_\_\_\_\_ Do you have health insurance? \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Are you covered under additional (group or individual) health policy through yourself or spouse? \_\_\_\_\_

Name of insurance company of additional coverage: \_\_\_\_\_

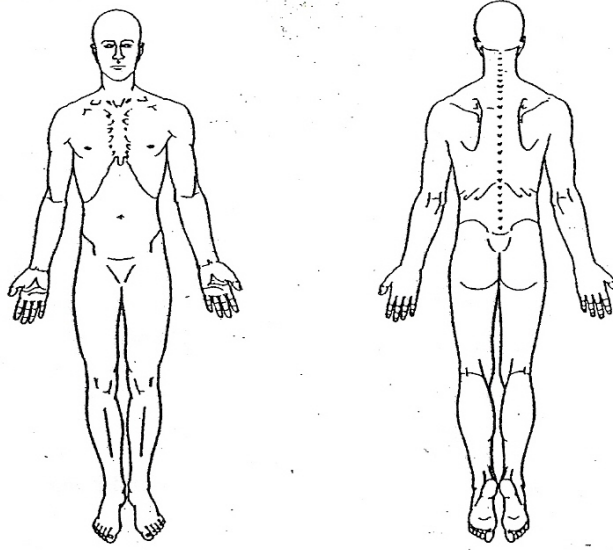
Medications you take now:  Aspirin  Pain Killers  Tranquilizers  Insulin  Birth Control Pills  Other (please list) \_\_\_\_\_

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- RELIEF CARE: Symptomatic relief of pain or discomfort
- CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms
- COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition

Patient signature: \_\_\_\_\_

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity, which brings on or aggravates the pain. For example, describe as dull, sharp, constant, off & on, when standing, when sitting, etc.



Check appropriate squares (x) past or (✓) present condition:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Mental, emotional conditions | <input type="checkbox"/> Bursitis               | <input type="checkbox"/> Kidney troubles         |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Convulsions                  | <input type="checkbox"/> Thyroid condition      | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Acne                         | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Colitis                 |
| <input type="checkbox"/> Head colds          | <input type="checkbox"/> Eczema                       | <input type="checkbox"/> Cough                  | <input type="checkbox"/> Dysentery               |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hay Fever                    | <input type="checkbox"/> Difficult breathing    | <input type="checkbox"/> Diarrhea                |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Adenoids                     | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Ruptures                |
| <input type="checkbox"/> Nervous breakdown   | <input type="checkbox"/> Hearing loss                 | <input type="checkbox"/> Heart condition        | <input type="checkbox"/> Hernias                 |
| <input type="checkbox"/> Chronic tiredness   | <input type="checkbox"/> Ringing ear                  | <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Cramps                  |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Laryngitis                   | <input type="checkbox"/> Pleurisy               | <input type="checkbox"/> Varicose veins          |
| <input type="checkbox"/> Sinus troubles      | <input type="checkbox"/> Hoarseness                   | <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Bladder troubles        |
| <input type="checkbox"/> Eye problems        | <input type="checkbox"/> Sore throat                  | <input type="checkbox"/> Congestion             | <input type="checkbox"/> Menstrual problems      |
| <input type="checkbox"/> Excessive sweating  | <input type="checkbox"/> Tonsillitis                  | <input type="checkbox"/> Influenza              | <input type="checkbox"/> Miscarriages            |
| <input type="checkbox"/> Ear ache            | <input type="checkbox"/> Croup                        | <input type="checkbox"/> Gall bladder condition | <input type="checkbox"/> Bed wetting             |
| <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Poor circulation             | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Impotency               |
| <input type="checkbox"/> Stomach troubles    | <input type="checkbox"/> Swollen ankles               | <input type="checkbox"/> Shingles               | <input type="checkbox"/> Change of life symptoms |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Cold feet                    | <input type="checkbox"/> Liver condition        | <input type="checkbox"/> Knee pain               |
| <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Weakness in legs             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Sciatica                |
| <input type="checkbox"/> Gastritis           | <input type="checkbox"/> Leg cramps                   | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Difficult urination     |
| <input type="checkbox"/> Lowered resistance  | <input type="checkbox"/> Hemorrhoids (piles)          | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Painful urination       |
| <input type="checkbox"/> Diabetes            |   |   | <input type="checkbox"/> Frequent urination      |

**PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.**

Our office uses sign in sheets, travel cards and provides care in an “open door” adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient’s histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/addresses, please let us know.

Patient’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Privacy Policy Received  
 Patient’s Signature \_\_\_\_\_ Date \_\_\_\_\_