Chiro Intake Form

1. Date:

Name: | Age: | Date of Birth:

Address: | Apt./Unit #: | City: | State: | Zip Code:

Phone: | Driver's License Number: | Sex:

Marital Status: | No. of Children: | Occupation:

Employer: | # of Years Employed: | Work Phone:

Email | Referred by:

Height | Weight

Shoe Size | Specific Areas of Pain

2. Do you have health insurance?
○ Yes ○ No

Do you have chiropractic benefits?
○ Yes ○ No

Insurance Company Name: | Insurance ID Number: | Subscriber's Employer:

Subscriber's Name: | Relationship to Patient: | Date of Birth:

3. Date problem began:

4. **Has the pain gotten:**

○ Better ○ Worse ○ No change

5. How bad is your pain?

6. **How often are your symptoms present?**

○ Constant ○ Frequent ○ Occasional

7. Please describe your problem and how it began:

8. Describe your pain/symptoms:

- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aches
- ☐ Dull
- ☐ Numbness
- ☐ Soreness
- ☐ Shotting
- ☐ Burning
- ☐ Tingling
- ☐ Weakness
- ☐ Gripping

9. What makes the pain better?

- ☐ Standing
- ☐ Lying down
- ☐ Walking
- ☐ Exercise
- ☐ Sitting
- ☐ Movement
- ☐ Stretching
- ☐ Nothing

10. What makes the pain worse?

- ☐ Standing
- ☐ Lying down
- ☐ Walking
- ☐ Exercise
- ☐ Sitting
- ☐ Movement
- ☐ Stretching
- ☐ Nothing

11. What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

12. Have you had X-rays, MRIs or other tests for this condition? What tests and when?

	Test	Date
1		
2		
3		

13. Health History—Do you have any of the following:

- ☐ Abdominal pain
- ☐ Cancer
- ☐ Infection
- ☐ Emphysema
- ☐ Chest pain/conditions
- ☐ Lung problems
- ☐ Jaw pain
- ☐ Aneurysm
- ☐ Digestive problems
- ☐ Rash
- ☐ Blood disorder
- ☐ Arthritis
- ☐ Diabetes
- ☐ Heart problems
- ☐ Sinus/Allergies
- ☐ Other
- ☐ Asthma
- ☐ Dermatitis
- ☐ High blood pressure
- ☐ Ulcer
- ☐ HIV/AIDS
- ☐ Headaches
- ☐ Stroke

Specify if other:

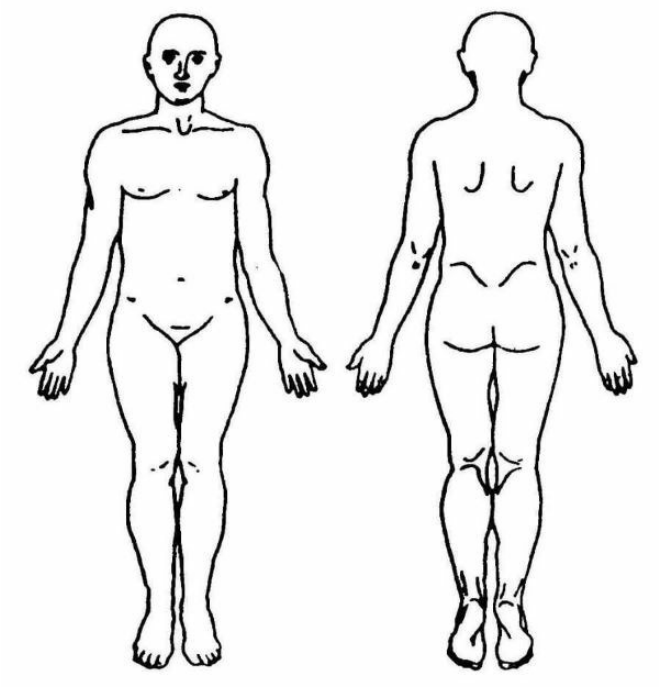
_____

14. Describe your job requirements:

- ○ Mainly sitting
- ○ Light labor
- ○ Heavy labor

15. Mark on the picture where you have pain or other symptoms. Include symptoms of pain, numbness, or tingling.

0 - Pain 1 - Numbness 2 - Tingling



16. Please read before signing:

- ☐ I clearly understand and agree that I am responsible for payment of any and all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during the treatment.
- ☐ I, the undersigned, affirm that the above is true and conect, and consent to chiropractic care in this office.

Patient

_____

Signature

17. _____