NEW PATIENT INTAKE

Name: _____ Date: _____
Address: _____ City: _____ Zip _____
Home Telephone: _____ Work: _____ Cell: _____
Email Address: _____ Male: ☐ Female: ☐
Social Security # _____ Birth Date: _____ Age: _____
Occupation: _____
Employer Name & Address: _____
Single: ☐ Divorced: ☐ Widowed: ☐ Other: ☐ Married: ☐ Spouse's Name: _____

Have you seen a Chiropractor before? Yes ☐ No ☐ If yes, when: _____

Whom may we thank for referring you to our office? _____

Your Health Summary

PLEASE check all the symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins & needles in legs	☐ Fainting	☐ Nervousness
☐ Pins & needles in arm	☐ Loss of smell/taste	☐ Back pain	☐ Upset stomach
☐ Dizziness	☐ Buzzing/ringing in ears	☐ Irritability	☐ Tension
☐ Numbness in fingers	☐ Numbness in toes	☐ Cold hands	☐ Cold feet
☐ Fatigue	☐ Depression	☐ Fever	☐ Hot flashes
☐ Sleep problems	☐ Neck stiffness	☐ Problem urinating	☐ Heart burn
☐ Diarrhea	☐ Constipation	☐ Menstrual irregularity	☐ Ulcers
☐ Cold sweats	☐ Sensitivity to light	☐ Neck pain	☐ High blood pressure
☐ Mood swing	☐ Menstrual pain	☐ Loss of balance	☐ High cholesterol

List any medications you are taking: _____

This office conforms to current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollections and I agree to allow this office to examine me for further evaluation

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____