CHIROPRACTIC CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
Information collected about new clients is confidential and will be treated accordingly.

PATIENT DETAILS

Patient Name: _____ **Date of Birth**: _____
SSN: _____ **Sex**: ☐ Male ☐ Female ☐ Other: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____
Home Phone: _____ **Mobile Phone**: _____
Work Phone: _____ **E-Mail**: _____
Preferred Contact Method: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ E-Mail
# of Children: _____ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse Name: _____ **Phone**: _____
Employer (if any): _____ **Job Title**: _____
Primary Physician: _____ **Phone**: _____
Have you been to a chiropractor before? ☐ Yes ☐ No

- If so, how long ago? _____ Where? _____

Emergency Contact Information

Emergency Contact: _____ **Phone**: _____
Relationship to Patient: _____

INSURANCE POLICIES

Primary Insurance Company: _____
Group #: _____ **ID #**: _____
Policyholder Name: _____ **Date of Birth**: _____
Relationship to Patient: _____

Secondary Insurance Company: _____
Group #: _____ **ID #**: _____
Policyholder Name: _____ **Date of Birth**: _____
Relationship to Patient: _____

SYMPTOMS

List the areas on your body where you experience pain:

Describe your symptoms in order of severity, beginning with the worst symptom:

How long ago did your symptoms begin? _____

What caused your symptoms? ☐ Motor Vehicle Accident ☐ Work Accident ☐ Other

- If other, explain: _____

How often do your symptoms occur?

☐ Constantly (76%-100% of the day) ☐ Frequently (51%-75% of the day) ☐ Occasionally (26%-50% of the day) ☐ Intermittently (0%-25% of the day)

What makes your symptoms better? _____

What makes your symptoms worse? _____

PATIENT HEALTH INFORMATION

Indicate the medical conditions that you have had:

☐ Arthritis ☐ Diabetes ☐ Hypertension ☐ Skin Disorder
☐ Cancer ☐ Heart Disease ☐ Psychiatric Illness ☐ Stroke
☐ Other: _____

Indicate the surgeries that you have had:

☐ Appendectomy ☐ Gastrointestinal ☐ Prostate
☐ Brain ☐ Hernia ☐ Shoulder
☐ Cardiovascular Procedure ☐ Hysterectomy ☐ Thoracic Spine
☐ Carpal Tunnel ☐ Joint Replacement ☐ Urogenital
☐ Cervical Spine ☐ Knee ☐ Other: _____
☐ Gallbladder ☐ Lumbar Spine

Indicate the allergies that you have:

☐ Eggs ☐ Milk/Lactose ☐ Soy
☐ Fish/Shellfish ☐ Peanuts ☐ Wheat/Gluten
☐ Other: _____

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks per week? _____

Do you smoke cigarettes? ☐ Yes ☐ No

- If yes, how many cigarettes per day? _____

Do you chew tobacco? ☐ Yes ☐ No

- If yes, how often? ☐ Frequently ☐ Occasionally ☐ Rarely

Do you drink caffeine? ☐ Yes ☐ No

- If yes, how many cups per day? _____

How often do you exercise? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

How often do you wear a seatbelt? ☐ Always ☐ Occasionally ☐ Never

List any prescription medications you currently take:

_____

FAMILY HISTORY

Indicate any health issues your family members have, and enter the age of the corresponding individual. If the person is deceased, enter their age at death.

Condition	Father Age: ____	Mother Age: ____	Siblings Age: ____	Children Age: ____
Arthritis	☐	☐	☐	☐
Asthma/Hay Fever	☐	☐	☐	☐
Back Trouble	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Disc Problems	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Kidney Trouble	☐	☐	☐	☐
Liver Trouble	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Pinched Nerve	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐
Stomach Trouble	☐	☐	☐	☐
Other:	☐	☐	☐	☐

ACKNOWLEDGMENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or other channels.
f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____

Parent or Guardian Signature: _____ **Date**: _____

Print Name: _____