

Chiropractic Intake Form

Patient information	
Full name:	Date of birth:
Phone number:	Email address:
Address	
City:	
State:	
ZIP code:	
Reason for seeking chiropractic care:	
Specific concerns or symptoms:	
Background information (e.g., injury details, previous treatments):	
Emergency contact information	
Name:	
Phone number:	
Email:	
Health history	
Do you have any past or current medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify:	

Are you currently taking any medications? Yes No

If yes, please list:

Have you undergone any surgeries? Yes No

If yes, please list:

Physical health conditions (select all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Back pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Spasms/cramps | <input type="checkbox"/> Heart issues | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Bone problems | <input type="checkbox"/> Rashes | <input type="checkbox"/> Vision problem |
| <input type="checkbox"/> Spinal cord issues | <input type="checkbox"/> Sprains | <input type="checkbox"/> Blood clotting | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose veins | |

Insurance details

Insurance provider:

Policy number:

Referral source

How did you hear about us?

- Friend/family
- Online search
- Social media
- Other:

By signing below, I confirm that the information provided is accurate to the best of my knowledge.

Signature:

Date: