

Chiropractic Intake Form

Client Information			
First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status
Address		City	State Zip Code
Email		Preferred Phone Number	
Emergency Contact			
Full Name	Relationship	Contact Number	
Full Name	Relationship	Contact Number	
Insurance Information (If Applicable)			
Insurance Carrier	Insurance Plan	Contact Number	
Policy Number	Group Number	Social Security Number	
Medical Information			
Primary Concern			
When did you start experiencing this issue?			
Physical Health Conditions (Select all that applies)			
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Issues	<input type="checkbox"/> Rashes	
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Bone Problems	<input type="checkbox"/> Blood Clotting	
<input type="checkbox"/> Spams/Cramps	<input type="checkbox"/> Sprains	<input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizure	
<input type="checkbox"/> Spinal Cord Issues	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hips Pain	
<input type="checkbox"/> Legs Pain	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Vision Problem	
<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Other:		

Client Information			
First Name	Last Name	Date of Birth	Gender
Medical Information (Continued)			
Please list any past or current injuries			
Please list any past surgeries			
Please list any current medications			
<p>On a scale of 1(least pain) to 10(worst pain), how much pain are you in right now?</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10</p> <p>What type of pain are you in right now?</p> <p><input type="checkbox"/> Numbness <input type="checkbox"/> Sharp Pain <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Dull Pain <input type="checkbox"/> Stiffness</p>			
How often do you exercise?			
<p>What type of exercise do you do?</p> <p><input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> None</p>			
All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.			
Parent or Guardian Name (If Applicable)		Relationship to Patient (If Applicable)	
Signature of Client, Parent or Guardian		Date	