

New Patient Intake, Chiropractic

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Patient information

LEGAL LAST NAME	LEGAL FIRST NAME	MIDDLE	DATE OF BIRTH
STREET ADDRESS		CITY	STATE ZIP
CELL PHONE	EMAIL	PREFERRED CONTACT ☐ Text ☐ Call ☐ Email	
EMERGENCY CONTACT NAME / RELATIONSHIP		EMERGENCY CONTACT PHONE	

Insurance (bring your card; we will scan it)

INSURANCE COMPANY	MEMBER ID (EXACTLY AS ON CARD)	GROUP #
POLICYHOLDER NAME (IF NOT YOU)	POLICYHOLDER DOB	RELATIONSHIP TO YOU ☐ Self ☐ Spouse ☐ Parent
Do you have a second insurance plan? ☐ No ☐ Yes (please give the card to the front desk)		

Your visit today

WHAT BRINGS YOU IN? WHERE IS THE PAIN OR PROBLEM?

WHEN DID IT START? HOW DID IT START? SEVERITY NOW (0 TO 10)

Is this visit related to: ☐ A car accident ☐ A work injury ☐ Another accident ☐ None of these

IF AN ACCIDENT: DATE, STATE, AND ATTORNEY OR CLAIM CONTACT IF YOU HAVE ONE

Health history

CURRENT MEDICATIONS	ALLERGIES
SURGERIES OR HOSPITALIZATIONS	PRIOR CHIROPRACTIC CARE? WHERE AND WHEN?
Check any that apply: ☐ High blood pressure ☐ Diabetes ☐ Osteoporosis ☐ Cancer history ☐ Stroke history ☐ Pregnancy ☐ Pacemaker ☐ Blood thinners	
PATIENT SIGNATURE	DATE

This template is general information; adapt it with your compliance advisor and pair with your consent to treat, privacy notice, and financial policy.
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