

**CHIROPRACTIC CLIENT INTAKE FORM**

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

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| **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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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 [ ]  Frequently [ ]  Occasionally [ ]  Intermittently

(76%-100% of the day) (51%-75% of the day) (26%-50% of the day) (0%-25% of the day)

**What makes your symptoms better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your symptoms worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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:

1. **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or Guardian Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_