New Patient Intake

Name:_____Today's Date:_____

Address:_____City_____State___Zip_____

Home Phone: ( )_____ Work: ( )_____ Cell: ( )_____

We use text messaging for appointment reminders. Who is your cell phone carrier?_____

Email Address: _____ Male:_____ Female: _____

Social Security #: _____ Birth Date: _____ Age: _____

Occupation: _____

Employer Name and Address: _____

Single: _____ Married: _____ Spouse's Name: _____

Have you seen a chiropractor before? Yes No If yes, when?_____

Whom may we thank for referring you to our office? _____

Your Health Summary

Check all symptoms you have ever had, even if they do not seem related to your current issue

□Headaches/Migraines	□Numbness/Tingling	□Back Pain	□Neck Pain
□Radiating Pain	□Loss of balance	□Fatigue	□Insomnia
□ADD/ADHD	□Reflux/GERD	□Dizziness	□Tension
□Ear Infections	□Chronic Pain	□Anxiety	□Depression
□Disc Degeneration	□Autism/Sensory Disorder	□Thyroid	□Sciatica
□Immunity Issues	□Fertility Issues	□Sinus Issues	□Bed Wetting

List any medications you are taking:_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability__

The statements made on this form area accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Guardian Signature: _____