Chiropractic Patient Intake Form

Personal Information

First Name

Last Name

Date of Birth

Gender

Address

City

State

ZIP

Phone

Email

Emergency Contact

Name

Phone

Relationship

Insurance Information

Insurance Provider

Policy Number

Group Number

Health Information

Primary Complaint/Reason for Visit

Describe your symptoms

Pain Level (1-10)

Have you received chiropractic care before?

Medical History

List any medical conditions

List any current medications

List any allergies

Lifestyle

Do you exercise regularly?

Do you smoke?

Do you consume alcohol?

Signature

Signature

Date