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)

- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Spams/Cramps
- ☐ Constipation
- ☐ Spinal Cord Issues
- ☐ Neck Pain
- ☐ Legs Pain
- ☐ Kidney Disorder
- ☐ Heart Issues
- ☐ Bone Problems
- ☐ Sprains
- ☐ Arthritis
- ☐ Chronic Cough
- ☐ Back Pain
- ☐ Infectious Disease
- ☐ Other:
- ☐ Rashes
- ☐ Blood Clotting
- ☐ Varicose Veins
- ☐ Seizure
- ☐ Asthma
- ☐ Hips Pain
- ☐ Vision Problem

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

On a scale of 1(least pain) to 10(worst pain), how much pain are you in right now?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What type of pain are you in right now?

☐ Numbness ☐ Sharp Pain ☐ Tingling ☐ Burning ☐ Dull Pain ☐ Stiffness

How often do you exercise?

What type of exercise do you do?

☐ Heavy ☐ Moderate ☐ Light ☐ None

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