NEW PATIENT INTAKE

rising CHIROPRACTIC

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Email Address: _____ Biological Sex: _____ *If your gender identity is different from your bio sex, please write it on this form, so that we may honor you.

SSN: _____ Birth Date: _____ Age: _____

Name of Employer _____ Occupation: _____ Retired? _____

Describe Job Duties: _____

Marital Status: _____ Spouse's Name: _____ Number of Children: _____

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, when: _____

How did you find us? ☐ Community Event, which _____ ☐ Referral, who _____

☐ Facebook Ad ☐ Google ☐ Other, _____

YOUR HEALTH HISTORY

Please ✓ check all symptoms you ***have ever had***, *even if they do not seem related to your current problems*.

☐ Headaches	☐ Pins/Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins/Needles in arms	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleep Problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Cold Sweats	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Mood Swings	☐ Lights bother eyes	☐ Problems urinating	☐ Heartburn
☐ Menstrual Pain	☐ Menstrual irregularity	☐ Ulcer	☐ Other _____

List any Family History of the above (or other) symptoms: _____

List any diseases, health conditions or surgeries: _____

Main Complaint: _____

List all medications you are taking: _____

Have you ever been in a car crash/collision? ☐ No ☐ Yes, when _____

How would you rate your overall health? _____

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

Patient/Guardian Signature: _____ Date: _____

Office Use Only HR#: _____