INTAKE FORM

Patient Name: _____ Today's Date: _____

Address: _____ Apt:_____

City: _____ State: _____ Zip: _____

Cell: _____ Work: _____ Home: _____

Email: _____ Date of Birth: _____ Age: _____

Insurance Company: _____ ID#_____ Group#_____

Gender: M F Other Marital Status: M S W D

Social Security#: _____ Ethnicity: _____

Occupation and weekly hours you work: _____

Emergency Contact's Name: _____ Phone: _____

Where / Who did you hear about us from: _____

Have you had acupuncture before: Y N
Have you had chiropractic before: Y N
Have you had physical therapy before: Y N
Are you currently pregnant? Y N Not sure
HIV Y N Not sure / Hepatitis Y N Not sure

3 CHIEF COMPLAINTS YOU WOULD LIKE TO FOCUS ON:

1:_____
2:_____
3:_____

OTHER SIGNIFICANT HEALTH INFORMATION:

_____
_____

MARK AREAS OF PAIN AND DISCOMFORT: