Confidential Patient Intake Form

Name: _____ Sex: M or F (Circle) D.O.B : ____ / ____ / _____

Address: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Guardian/Spouse Name: _____ D.O.B : _____

Health Insurance Company: _____

Insurance Subscriber Name: _____ D.O.B : _____

Who Told You About Our Office? _____

Reason for Your Visit Today? ☐ Auto Collision/Injury ☐ Work Injury ☐ Other: _____

Briefly Describe Your Health Goals: _____

CHECK ANY OR ALL THAT APPLY TO YOUR PRESENT HEALTH:

☐ **h**eadaches	☐ chronic pain	☐ varicose veins	☐ vision problems	☐ muscle/joint pain
☐ blood clots	☐ sinus problems	☐ tobacco use	☐ sprains/strains	☐ numbness/tingling
☐ diabetes	☐ fatigue	☐ scoliosis	☐ cancer/tumors	☐ high/low blood pressure
☐ depression	☐ arthritis	☐ sleep difficulties	☐ infectious disease	☐ jaw pain/ teeth grinding
☐ stroke	☐ tendonitis	☐ BMI > 25%	☐ exercise ___x/week	☐ skin problems/allergies
Women Only:	☐ Pregnant	☐ Endometriosis	☐ Painful Menstruation	

Other not listed: _____

List all medications/herbs/vitamins and dosage: _____

What movements or activities are limited (What aggravates it?): _____

List previous major injuries/surgeries: _____

What other treatments are you receiving and by whom (chiropractic, acupuncture, PT, naturopathic?):

_____

I understand and agree that health and motor vehicle insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be check if Back to Action Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctor at Back to Action Chiropractic , and whomever they may designate as their assistant, to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient (or Parent/Guardian) Signature: _____ **Date:** _____