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**Patient Intake Form**

Name: Today's Date: Address: City: State: Zip:

Cell Number: ( ) Work: ( ) Home: ( )

Email Address: Male Female

Birth Date: Single Married Occupation:

Employer Name: \_ ­­­­ \_\_\_\_\_\_\_

Name & Phone # of Emergency Contact: \_\_ Relationship:

Have you seen a Chiropractor before? **Yes No** If yes, when?

Whom may we thank for referring you to our office?

 **YOUR HEALTH SUMMARY**

What is the purpose for your visit?  Wellness  Complaint  Injury  Other:

Please list any spinal related symptoms you are experiencing:

Please list any other health related symptoms you are experiencing:

Have you ever…  been in an auto accident  fallen/been injured at work  broken or sprained a bone

  been struck unconscious  had a concussion  had surgery

 If you checked any of the boxes above, briefly explain:

 List of Current Medications:

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 Signature: Date:

Guardian Signature: Date: