EVERGREEN CHIROPRACTIC-PATIENT INTAKE FORM

Name: _____ Today's Date: ___/___/___

Social Security Number ☐☐☐☐☐☐☐☐☐ Birth Date: ___/___/___ Age: ____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Guardian / Foster Parent: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Who do you normally live with (check all that apply)? ☐ Father ☐ Mother ☐ Guardian / Foster Parent

☐ Grandparent(s) ☐ Brother(s) / Sister(s) ☐ None of These

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Your Email Address _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? ___/___/____

-- OVER --

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

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Date of last physical examination? _____

What operations have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

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I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____