PATIENT INTAKE FORM

Last Name	First Name		MI
Address			Apt
City	State	Zi	p
SSN #	_ Birthdate	Age	# of Children
Cell # Home :			
Email			
Spouse			
Primary Physician			
Major complaint:	Have you had this or a similar Do you ever experience this p	condition in the past?	
Is this condition getting progressively worse? Yes			
	Neck Problems Shoulder Problems Arm Problems Numbness - Arms Pain between Shoulders Low Back Problem Leg Problems Numbness - Legs Loss of Feeling Stiff Joints Painful Joints Restricts Daily Activity Restricts Exercise Tiredness/Fatigue	Sore Muscles Walking Probler Broken Bones Muscle Cramps Weak Muscles Headaches Dizziness Fainting Forgetfulness Depression Vision Problems Ear Infections Frequent Colds Hearing Loss	Asthma Eczema Shingles Nausea Poor Digestions Ulcers Diarrhea Constipation Kidney Infection Diabetes
This is a new / old illness. It was / was not treated. If treated before, what was done? Name of Doctors: Have you ever had surgery or been hospitalized? Yes No List of Surgeries: Have you ever had chiropractic care? Doctor Date Last time you had spinal x-rays Medications_ Car accidents Falls/Injuries		History / Consulta	tion
Sign & Date			