Hensley Chiropractic

Patient Intake Form

Today's Date: ____/____/____ **Patient Information**

Name:_____ Birthdate:____/____/____ Gender: M / F

Mailing Address:_____ City_____ Zip_____

Telephones: Home:_____ Cell:_____ Work:_____

Email address for chiropractic newsletter (optional): _____

Occupation: _____ Religious preference: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Spouse name:_____ Children:_____

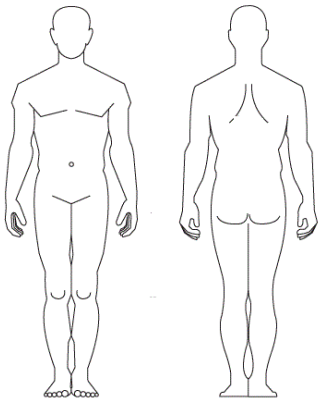
Insurance Information:

Company Name:_____ Group#_____ ID#_____

Primary subscriber name:_____ Subscriber's date of birth:____/____/____

Insurance Phone Number:_____

Mark on the diagram where you have pain or other symptoms:



Front Back

Describe your current complaint: Date of onset:_____

_____

_____

_____

Personal Health History: *Please check all that apply to you*.

Condition	Yes	No	Condition	Yes	No
Recent infection	___	___	History of neck pain	___	___
Recent fever	___	___	History of back pain	___	___
Diabetes	___	___	Numbness in arms	___	___
Are you pregnant?	___	___	Numbness in legs	___	___
Rheumatoid arthritis	___	___	Dizziness/fainting	___	___
Cancer/tumor	___	___	Cardiovascular issue	___	___
Epilepsy/seizures	___	___	Alcohol abuse	___	___
High Blood pressure	___	___	Tobacco use	___	___
Osteoporosis	___	___	Recent trauma	___	___
Osteoarthritis	___	___	Broken bones	___	___
Stroke or TIAs	___	___	Scoliosis	___	___
Vision problems	___	___	Other:_____		
Past kidney problems	___	___	_____		