

# Chiropractic Intake

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PLEASE PRINT CLEARLY

Name: \_\_\_\_\_  
Last First MI

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Address: \_\_\_\_\_  
Street

Home Phone: \_\_\_\_\_  
City State Zip

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name & phone number.

Is MEDICARE your primary insurance? Y / N  
If YES, do you have secondary insurance? Y / N  
*Please provide your Medicare and secondary insurance cards for copy.*

If you have chiropractic coverage with any insurance other than Medicare and would like a statement provided to you for reimbursement, please check here.

Were you involved in an auto accident? Y / N

Are your symptoms a result of an injury at work? Y / N

Chief complaint (why are you seeking treatment?) \_\_\_\_\_

How did this begin? \_\_\_\_\_

When did this begin? \_\_\_\_\_

Has this happened before? Y / N Were you treated for this before? Y / N

Previous treatment: \_\_\_\_\_

Since the problem began, it has:  Improved  Worsened  Not changed

The problem bothers me:

Occasionally (0-25% of the time)  Intermittently (26-50%)  Frequently (51-75%)  Constantly (76-100%)

Rate your pain as you feel today: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  
No pain Moderate Unbearable

Do you notice your pain mostly in the:  Morning  Afternoon  Night

Any other associated symptoms? \_\_\_\_\_

My signature, below, certifies that I am aware that all services are payable when treatment is rendered; that I understand I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Dr. Cox and any emergency transportation that may be required thereto; that the preceding questions have been answered truthfully and complete to the best of my knowledge and belief.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

