Chiropractic/ Physical Therapy Intake Form

Name ____________________________________ Today's Date __________ Date of Injury __________

Home Phone _______________ Work Phone _______________ Cell Phone _______________

Home Address __________________________________ City/State _______________ Zip Code _________

Employer ______________________________ Occupation ______________________________

Date of Birth ____________ Marital Status _________________________

Emergency Contact ____________________ Relationship ______________ Phone ______________

Who may we thank for referring you to our office? ____

If you found us in the yellow pages, do you remember which one? ______________________________

Is your visit due to an auto accident? Yes/No Is your visit due to another accident (ex. work)? Yes/No

Your present complaint/symptoms ____

List other doctors seen for this condition ____

How would you describe your discomfort? ____

Intensity: ____________ mild __________ moderate ____________ severe ____________ other: __________

Duration: ____________ constant _______ intermittent __________ with certain motions ________________

Medical History (Please circle any that you have experienced)

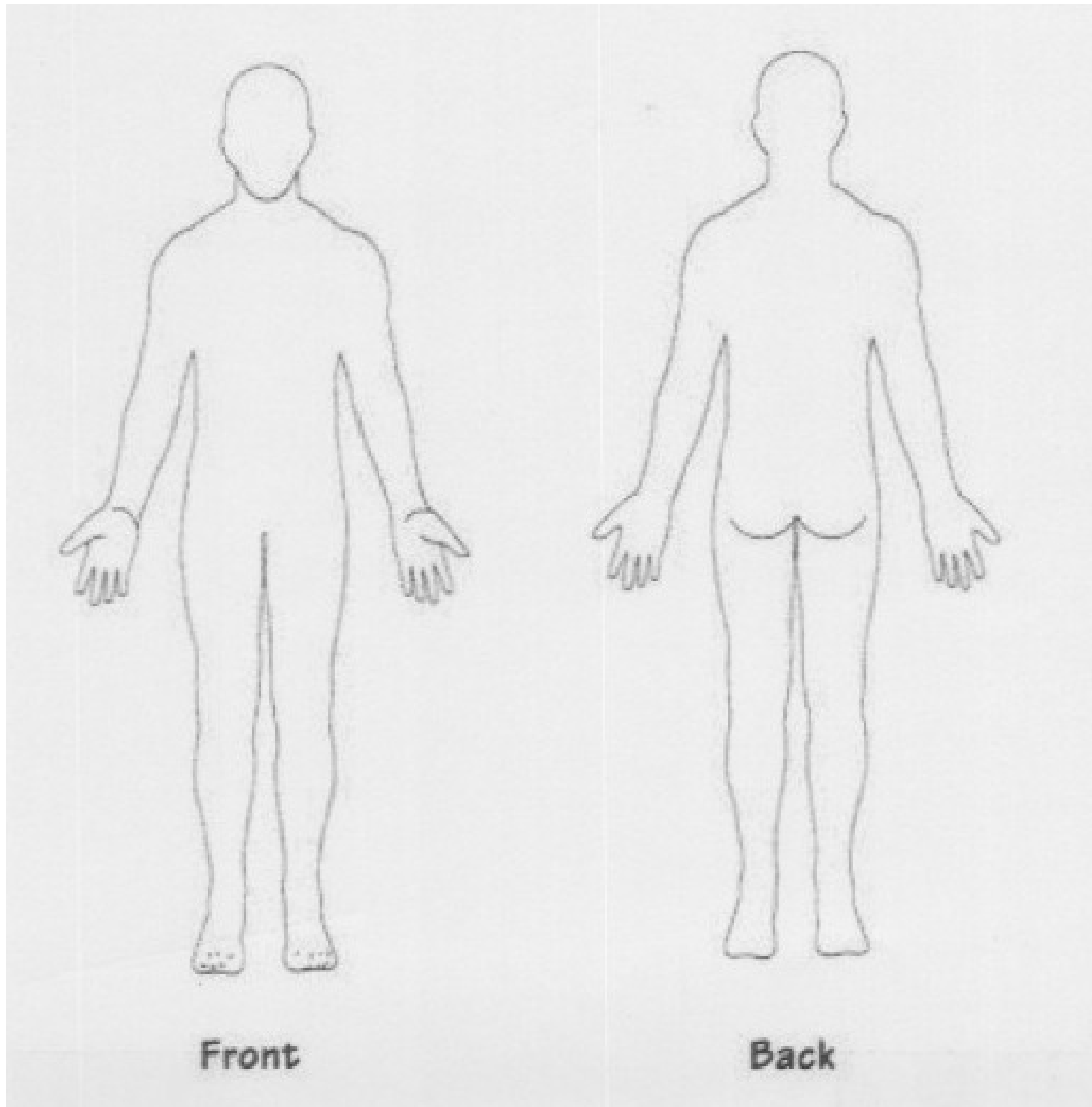
ADD	Cancer	Hepatitis	Numbness/Tingling
Anxiety	Concussion	High Blood Pressure	Sinus Trouble
Arthritis	Diabetes	Irritable Bowel Syndrome	Stress
Asthma	Digestive Disturbances	Multiple Sclerosis	Tuberculosis
Backache	Epilepsy	Muscular Dystrophy	

Have you been treated by a physician for any health conditions in the last year? Yes/No
If so, please describe ____

Any surgeries or orthopedic conditions? (Please List) ____
Are you taking any medications? Yes/No List medications ______________________________
Are you pregnant? Yes/No If yes, are your symptoms related to your pregnancy? Yes/No

Do you have insurance? Yes/No If no, how will you be paying today? Cash ___ Check ___ Credit Card ___
If yes, we will need to make a copy of your insurance card.
*If you have Great West Insurance, we will need your Social Security Number __________________

Place an X over painful or stiff areas



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare my necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. I hereby authorize Heritage Health and whomever they may designate as their assistants to administer treatment, as they do deem necessary. I authorize the release of my information acquired in the course of my examination or treatment. I certify that the above information is true and correct. I will notify you of any changes in my status or the above information.

Signature	Date	Signature of Parent (if minor)	Date