Infinite Chiropractic Intake Form

Patient #_____ *Always Confidential* *Date_____*

YOUR INFORMATION

Name_____

Preferred Name_____

Address_____

City_____State_____ Zip_____

Date of Birth____/____/_____Sex: ❒Male ❒Female

Social Sec#_____/_____/_____ Age_____

Spouse_____ Phone_____

Referred by:

CONTACT INFORMATION

Cell Phone (_____) _____ Would you like text reminders for future appts? Y❒ N ❒

Other Phone (_____) _____Work❒ Home❒

Email _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name _____

Phone (_____) _____ Relationship_____

Would you like your Chiropractic records sent to another health professional?

❒MD ❒PT ❒ND

INSURANCE INFORMATION

Injury type? Work❒ Auto Injury❒ Other❒ None❒

Insurance Coverage_____

Secondary Ins_____

Policy Holder's Name _____

CURRENT COMPLAINTS

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

STIFFNESS=

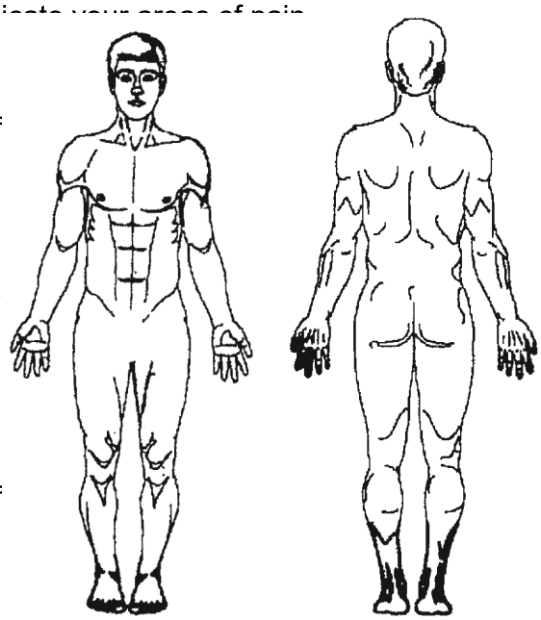
BURNING=B

TINGLING=T

PAIN=P

NUMBNESS=

ACHY=A



Pain Level: *(none)* 1 2 3 4 5 6 7 8 9 10 *(worst)*

Have you been treated for this before? ❒Yes ❒No

When was your last Chiropractic Treatment?

_____

ACTIVITY INTOLERANCE

Are there any activities that you can not do or are having a hard time with?

_____

SURGERY HISTORY

Please list all previous surgeries you've had.

_____

Women Only

Is there any chance you are pregnant? Y❒ N❒

If NO; I understand that x-ray can be harmful to a fetus. However, I believe that I am not pregnant and my health concerns warrant the risk for any necessary x-rays.

Signature_____