PREMIER CHIROPRACTIC + PERFORMANCE

Patient Intake Form

Patient Name:_____
Date:_____
Address:_____
Apt._____
City:_____ State:_____
Zip:_____
Birthdate:_____ Age:_____
SSN:_____
Home Phone:_____Work Phone:_____Cell Phone:_____
Email Address:_____ Name of Employer:_____
Marital Status: Married / Single
Primary Care Physician:_____
Phone:_____
Your Insurance Company:_____
Referral: Google / Yelp / Facebook / Instagram / Doctor / Friend/Family / Insurance / Billboard
Name of Referral (if person):_____

Describe your current complaint:

_____

Is this: Work Injury / Auto Injury **Date of Injury:**_____
Describe how your current complaints began:_____

_____

Date of most recent episode:_____
Rate your overall health: Excellent / Very Good / Good / Fair / Poor
(Females) Date of last menstrual cycle:_____

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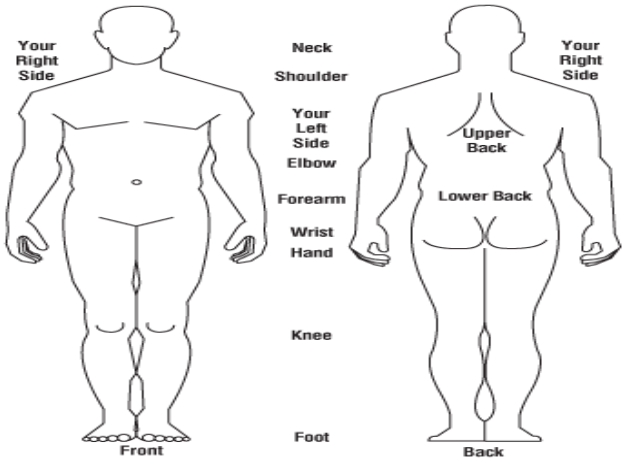
MARK AN "X" ON THE PICTUREWHERE YOU HAVE PAIN:



Please check all of the following that apply to you:

_____ Alcohol/Drug Dependent _____Tobacco Use _____Recent Fever

_____ Diabetes _____High Blood Pressure _____Stroke (Date:_____)

_____ Corticosteroid Use (Cortisone, Prednisone, etc) _____ Birth Control Pill _____ Abnormal Wt. Loss/ Gain

_____ Cancer/ Tumor (explain_____) _____ Epilepsy/ Seizure _____ Osteoporosis

Other Health Problems:

_____

****PLEASE SEE SECOND PAGE TO COMPLETE FORM****

List of all surgeries and dates performed:

_____

_____

____

_____

____

List of all Medications and Dosages:_____

_____

____

_____

____

Family History:

_____ Cancer _____ Diabetes _____ High Blood Pressure

_____ Heart Problems / Stroke _____ Rheumatoid Arthritis

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I certify to the best of my knowledge, the above information is complete and accurate.

Patient Signature:_____ Date: _____

Parent/ Guardian Signature: _____ Date: _____