LEGACY CHIROPRACTIC
Empowering Winners, Inspiring Champions

PATIENT INTAKE FORM

Date: ____/____/____ Patient ID# _____

PATIENT INFORMATION

Name _____ Age ____ Birthdate ____/____/____ Sex ☐ M ☐ F

Address _____ City, State _____ Zip _____

Phone _____ Email _____ Preferred form of contact ☐ Email ☐ Text

Occupation _____ Employer _____ Marital Status: S M D W

EMERGENCY CONTACT Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Name _____ ID # _____ Birthdate ____/____/____

Insurance Company _____

Name of Insured (if not patient)_____ Relationship_____ Birthdate ____/____/____

ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Yes ☐ No Date: ____/____/____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other Attorney Name (if applicable) _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

How did your symptoms start? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) ____

Type of pain: ☐ Sharp ☐ Dull ☐ Numb ☐ Stiff
☐ Burning ☐ Tingling ☐ Throbbing ☐ Ache

How often do you have this pain? _____

Is it constant or does it come and go? _____

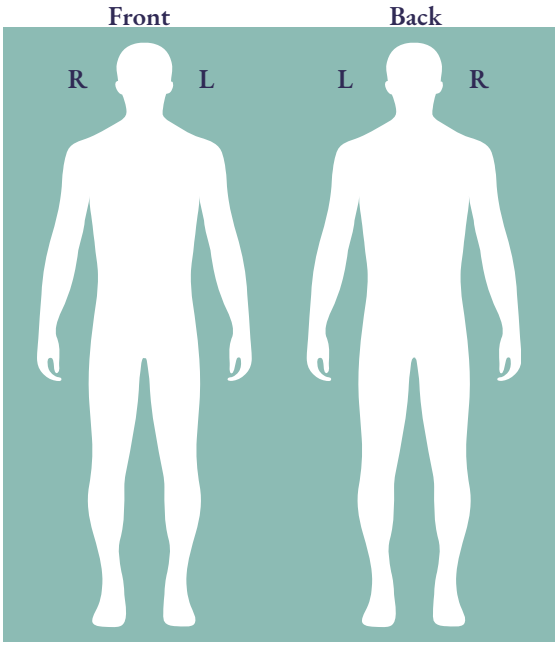
Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending

Women Only:
Are you pregnant? ☐ Yes ☐ No Due Date: ____/____/____

Mark an X on the picture where you continue to have pain, numbness, or tingling



HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None ☐ Other _____

Name & Phone Number of the other doctor(s) who have treated you for your condition _____

Date of last Xray ____/____/____ MRI/CT ____/____/____ Blood Test ____/____/____

Have you been to a chiropractor before? ☐ Yes ☐ No If so, who or technique used? _____

Please check off the boxes to indicate if you have had any of the following:

☐ Pacemaker	☐ Asthma	☐ Tumor
☐ Genetic Spinal Disorder	☐ Hepatitis	☐ Eye/Vision Problems
☐ Arthritis	☐ Ulcer/s	☐ Hearing Problems
☐ Diabetes	☐ High Blood Pressure	☐ Spinal Cord Injury
☐ Cancer	☐ Prostate Problems	☐ Neurological Disorder
☐ Depression/Other Disorder	☐ Menstrual Problems	☐ Rheumatoid Arthritis
☐ Epilepsy	☐ Stroke/Heart Attack	☐ Osteoporosis
☐ Dizziness	☐ Minor Heart Trouble	☐ Kidney Disease
☐ Fainting	☐ Broken Bones	☐ Other _____
☐ Fatigue	☐ Stomach Problems	_____

Injuries/Surgeries you have had

Falls _____ _____

Head Injuries _____ _____

Broken Bones _____ _____

Dislocations _____ _____

Surgeries _____ _____

Other Health History

Allergies _____

Previous Accidents _____

Family History _____

MEDICATION LIST	SUPPLEMENT LIST

HOW DID YOU FIND US?

Who referred you to our office? _____

Where did you hear about us? ☐ Google ☐ Facebook ☐ Instagram ☐ Magazine ☐ Event ☐ Other _____