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

How did your symptoms start? _____ Have you had these symptoms in the past? ☐ Yes ☐ No

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

How often do you have this pain?

☐ Constant (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

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

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other
Please Explain: _____

Activities or movements that are painful to perform

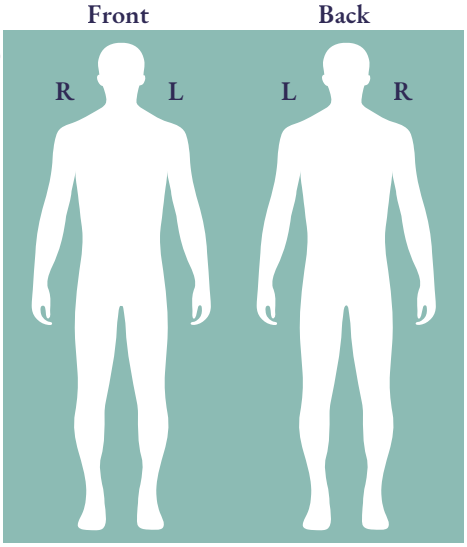
☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending ☐ Twisting

What treatments improve your symptoms?

☐ Heat ☐ Ice ☐ Stretching ☐ Adjustments ☐ Massage ☐ Rest

Women Section: 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?

☐ None ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ 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:

- ☐ Arthritis (Osteo/Degen)
- ☐ Arthritis (Rheumatoid)
- ☐ Arthritis (Psoriatic)
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Cancer _____
- ☐ Depression/Other Disorder
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Eye/Vision Problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Trouble_____
- ☐ Hepatitis/Liver Issues
- ☐ High Blood Pressure
- ☐ Hypermobility
- ☐ Kidney Disease
- ☐ Menstrual Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prostate Problems
- ☐ Spinal/Neurological Disorder
- ☐ Spinal Cord Injury
- ☐ Stomach/Digestive Issues
- ☐ Stroke/Heart Attack
- ☐ Tumor/s
- ☐ Ulcer/s
- ☐ _____
- ☐ _____
- ☐ _____

Injuries/Surgeries you have had

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____ Any metal/screws in your body?

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 _____