Marshall Chiropractic

Initial Patient Intake Form

Name: _____ Today's Date: _____
(First) (Middle Initial) (Last)

Date of Birth: __ / __/__ Month/Day/Year Email: _____ Home Phone: (___)____-_____

Alt. Phone: (___)____-_____ Occupation: _____ Sex: ☐ M ☐ F

Street Address: _____

City: _____ State: _____ Zip: _____

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

General Physician: _____ General Physician Phone: _____

Date Last seen: _____ Number of children: _____

Emergency Contact: _____ Emergency Contact phone: _____

Who referred you to this office? _____

Health Report:

Family:

1. Heart condition ? Y / N
2. Stroke? Y / N
3. Cancer? Y / N
4. Any other condition? Y/ N

Have you ever:

1. Suffered a trauma (including but not limited to a car accident, sport accident etc)? Y / N
   _____
   Is this under litigation? Y / N
2. Undergone surgery? Y / N If yes, please explain:
   _____
   Do you have any residual problems from the surgery (s)? Y / N If yes, please explain:
   _____
3. Been diagnosed with a Cardiovascular condition? Y / N If yes, please explain:
   _____
   If yes, do you take medications? _____
4. Been diagnosed with high cholesterol or high blood pressure? Y /N If yes, please explain:
   _____
   If yes, do you take medications? _____
5. Do you have allergies? Y / N If yes, please explain?
   _____

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For women: Have you had children? Y / N If yes, how many? _____
Were their births difficult/complicated? _____

Are you taking birth control? Y / N If yes, what kind? _____

Name of your previous chiropractor: _____
Have you had X-rays of your spine taken? Y / N
If yes, when were they taken? _____
Why are you seeking chiropractic care?
_____

I, _____, have filled out this form truthfully and to my best ability.

_____ _____
(Sign) (Date)