Intake Form

Name:	Date:
Address:	Primary Phone:
Date of birth:	Secondary Phone:
Current Age:	Email:
Were you referred by a doctor? ☐Yes ☐No	
If yes, Physicians name:	
Do you have extended medical coverage? ☐Yes ☐No	
Claim/Policy number:	Insurance Company:

Chief Complaint:

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Have you received any of the following services before?

Acupuncture: ☐Yes ☐No From:________________ To: ________________

Chiropractic: ☐Yes ☐No From:________________ To: ________________

Massage Therapy: ☐Yes ☐No From:________________ To: ________________

History of health problems such as chest pain or stroke? ☐Yes ☐No

Have you had chest pain brought on by physical activity? ☐Yes ☐No

Episodes of feeling faint, severe dizziness, seizure or epilepsy? ☐Yes ☐No

History of smoking? If yes, how many years? ☐Yes ☐No

History of breathing or lung problems? ☐Yes ☐No

Diabetes or thyroid conditions? ☐Yes ☐No

Has your doctor ever stated that you have joint problems such as arthritis that has been aggravated or made worse by exercise? ☐Yes ☐No

Elevated or low blood pressure? ☐Yes ☐No

Past surgeries? If yes, please describe and date… ☐Yes ☐No

Have you had any X-Rays done? If yes please explain… ☐Yes ☐No

Do you have any other past injuries or other known medical conditions which we should know about?