

VitaLife Chiropractic Patient Intake

Form

Patient Information First Name:		Date:			
Gender: Date of Birth: Email:	atient Information				
Primary Phone: Email: (your email will not be shared with any Address: City: State: Zip Code Marital Status: Single Married Divorced Widow/Widower Spouse's Name: Emergency Contact: Relationship: Phone: P	irst Name:	Last Nan			
Address:	ender: Date of Birth:				
Marital Status: Single Married Divorced Widow/Widower Spouse's Name: Emergency Contact:	rimary Phone:	Email:	(your	email will <u>not</u> be	shared with any 3rd partie
Billing Information Do you have health insurance? Yes No Insurance Company: Name of Policy Holder: May we discuss your medical record/billing with someone else? (i.e. spouse,parent) Yes No If yes, please indicate who we may speak with: Medical History Please list all Surgeries or Fractures: Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify: "If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secon Location of discomfort: Date condition began: How did the condition occur?	ddress:	Ci	ty:	State:	Zip Code:
Billing Information Do you have health insurance? Yes No Insurance Company:	Marital Status: Single Married [Divorced Widow/\	Vidower Spouse '	's Name:	
Do you have health insurance? Yes No Insurance Company: Name of Policy Holder:	mergency Contact:	Relati	onship:	Phon	e:
Do you have health insurance? Yes No Insurance Company: Name of Policy Holder:					
Do you have health insurance? Yes No Insurance Company: Name of Policy Holder:	illing Information				
Name of Policy Holder:	_	es No Insurance	Company:		
May we discuss your medical record/billing with someone else? (i.e. spouse,parent) Yes No If yes, please indicate who we may speak with:					
Medical History Please list all Surgeries or Fractures: Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secon Location of discomfort: Date condition began: How did the condition occur?	-				
Medical History Please list all Surgeries or Fractures: Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secont Location of discomfort: Date condition began: How did the condition occur?	•		, ,	•	•
Please list all Surgeries or Fractures:Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify:* If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second coation of discomfort:	yes, piedse maiedte who we may	, speak with			
Please list all Surgeries or Fractures:Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secont Location of discomfort: Date condition began: How did the condition occur? Date condition began:					
Please list all Surgeries or Fractures:Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify:* If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second coation of discomfort:	 Nedical History				
Please list all current medications that you are taking: (if you have a prepared list we can copy it) Current Complaints Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second to a discomfort: Date condition began: How did the condition occur?	-	·c·			
Current Complaints Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secon Location of discomfort: Date condition began: How did the condition occur?	_				
Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secon Location of discomfort: Date condition began: How did the condition occur?	lease list all current inedications	that you are taking	. (II you nave a prepare	d list we can copy	y it)
Is this related to Auto or Work Comp? If yes, please specify:* *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second continuous condition of discomfort:					
Is this related to Auto or Work Comp? If yes, please specify:* *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second continuous condition of discomfort:					
Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secon Location of discomfort: Date condition began: How did the condition occur?					
Is this related to Auto or Work Comp? If yes, please specify: *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a secon Location of discomfort: Date condition began: How did the condition occur?					
Is this related to Auto or Work Comp? If yes, please specify:* *If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second continuous condition of discomfort:	urrent Complaints				
*If this is related to an auto or work comp, please notify the receptionist as we will need additional information filled out on a second Location of discomfort: Date condition began: How did the condition occur?	·	2 ifl			
Location of discomfort: Date condition began: How did the condition occur?			,		
How did the condition occur?	***	•			
					p~
Current Pain Scale: (0-10 with 0 being none at all and 10 being the worst) please circle one bel					ircle one below:
0 1 2 3 4 5 6 7 8 9 10		_	_		