VitaLife Chiropractic Patient Intake Form

Date:__________

Patient Information

First Name:___________________________ **Last Name:**_________________________ **Mid Initial:**_____

Gender:_____ **Date of Birth:**______________ **Height:** ________ **Weight:**________

Primary Phone: ______________ **Email:**____________________ **(your email will not be shared with any 3rd parties)**

Address:__________________________________ **City:**______________ **State:**____ **Zip Code:**_____

Marital Status: Single Married Divorced Widow/Widower **Spouse's Name:**____________________

Emergency Contact: _____________________ **Relationship:**______________**Phone:**_______________

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Billing Information

Do you have health insurance? Yes No **Insurance Company:**_________________________________

Name of Policy Holder: _______________________________ **Date of Birth:**______________________

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)**

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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 form

Location of discomfort:__________________________________ **Date condition began:**_____________

How did the condition occur? ____

Current Pain Scale: (0-10 with 0 being none at all and 10 being the worst) please circle one below:

0 1 2 3 4 5 6 7 8 9 10