DR. GENA CHIROPRACTIC NEW PATIENT INTAKE

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Telephone Numbers Home: ( )_____ Mobile: ( )_____

Email Address: _____

Sex (circle one): F M O Date of Birth: _____ Age: _____

Occupation: _____ Employer: _____

Work Address: _____ Telephone: ( )_____

Status (circle one): Single Married Divorced Widowed

Spouse's Name: _____ Telephone: ( )_____

Primary Concern: _____

Have you been involved in a motor vehicle collision within the last three months? _____

Have you seen a chiropractor before? Yes No If yes, whom/when? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please check √ all symptoms you have ever had, even if they do not seem related to your current problems.

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Loss of Balance
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Back Pain	☐ Nervousness
☐ Dizziness/Vertigo	☐ Ringing in Ears	☐ Loss of Taste	☐ Upset Stomach
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Irritability	☐ Tension
☐ Fatigue	☐ Depression	☐ Cold Hands	☐ Cold Feet
☐ Sleeping Problems	☐ Neck Pain	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Constipation	☐ Problem Urinating	☐ Heartburn
☐ Mood Swings	☐ Lights Bother Eyes	☐ Menstrual Irregularity	☐ Seizures
☐ Stroke/TIA	☐ Menstrual Pain	☐ Neck Stiffness	☐ Reflux

☐ Other: _____

Are you pregnant? Yes No N/A

Do use tobacco products? Yes No If yes, how many years? packs per day? _____

Please list any previous surgeries, including year: _____

_____ N/A or None

List any medications that you are taking: _____

_____ N/A or None

Does anyone in your family have any medically-diagnosed conditions? If so, whom/which? _____

_____ N/A or None

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.
Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Patient Name Printed Legal Guardian Name Printed (if applicable)

_____ _____

Patient/Legal Guardian Signature Date