

New Beginnings Chiropractic Adult Patient Health Intake and Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:

Last Name:

Date:

SSN#:

DOB:

Male

Female

Marital Status:

#children:

Occupation:

Street Address:

Height:

City, State, Zip:

Weight:

Email:

Cell Phone:

Other Phone:

Emergency Contact:

Relationship:

Emergency Phone:

How did you hear about us? (Facebook, Google, Friend, etc)

Who is your primary care doctor?

Date and reason for your last doctor visit?

Are you receiving care from any other health professionals? If yes, please name them and their specialty.

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you to our office?

Have you received care for this problem before? Y N If yes, please explain:

When did the condition(s) first begin?

How did the problem start?

Is this condition : () Getting worse () Intermittent () Improving () Constant () Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your Top 3 Health Goals:

1)

2)

3)