Nordquist Family Chiropractic Intake Form

Patient #_____ ***Always Confidential*** ***Date_____***

YOUR INFORMATION

Name _____

Preferred Name_____

Address_____

City_____State_____ Zip_____

Date of Birth____/____/_____Sex: ❒Male ❒Female

Social Sec#_____/_____/_____ Age_____

Spouse_____ Phone_____

Referred by: _____

Google maps❒ Search engine❒ Friend❒ MD❒

Website❒ Advertisement❒ Other❒_____

Occupation_____

Employer_____

CONTACT INFORMATION

Cell Phone (_____) _____
Would you like text reminders for future appts?

Y❒ N ❒ Carrier_____

Other Phone (_____) _____Work❒ Home❒

Email _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name _____

Phone (_____) _____Relationship _____

Would you like your Chiropractic records sent to another health professional?

❒MD ❒PT ❒ND ❒Other_____

_____City_____

_____City_____

INSURANCE INFORMATION

Injury type? Work❒ Auto Injury❒ Other❒ None❒

Insurance Coverage_____

Secondary Ins_____

Policy Holder's Name _____

Relation to Patient _____DOB_____

CURRENT COMPLAINTS

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

STIFFNESS=S

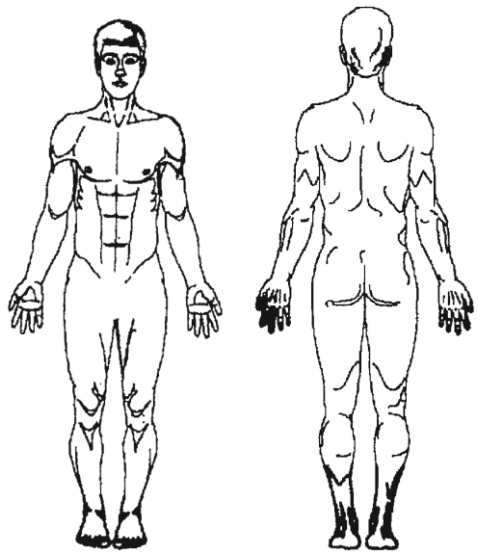
BURNING=B

TINGLING=T

PAIN=P

NUMBNESS=

ACHY=A



Pain Level: *(none)* 1 2 3 4 5 6 7 8 9 10 *(worst)*

Have you been treated for this before? ❒Yes ❒No
When was your last Chiropractic Treatment?

_____

ACTIVITY INTOLERANCE

Are there any activities that you are having a hard time with because of your symptoms?

_____

Anything you're not doing now that you would if you felt better?_____

FAMILY HISTORY

Please list any history of family illness

_____

_____

Women Only

Is there any chance you are pregnant? Y❒ N❒

If NO; I understand that x-ray can be harmful to a fetus. However, I believe that I am not pregnant and my health concerns warrant the risk for any necessary x-rays.

Signature_____