New Patient Intake Form

Date: _____ To whom did you speak to from our office: _____

Is this appointment for: ☐ You ☐ A family member Is this for: ☐ Specific problem ☐ Wellness care

Name: _____ Nickname: _____

Date of birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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

Cell #: _____ Home #: _____ Work #: _____

Occupation: _____ Employer: _____

Do you have someone joining you for this appointment: _____

Reason(s) for seeking care: _____

Have you seen another doctor for this condition? ☐ Yes ☐ No If yes, whom: _____

Have you received chiropractic care before: ☐ Yes ☐ No If yes, whom: _____

If you were referred, by whom: ☐ Family/friend ☐ Other physician ☐ Social media ☐ Internet search ☐ Other _____

Have you ever been in an accident: ☐ Yes ☐ No If yes, ☐ Work ☐ Auto ☐ Other: _____

When: _____ Nature of accident: _____

Did you require post-accident hospitalization: ☐ Yes ☐ No Did you lose workdays as a result: ☐ Yes ☐ No

How many: _____ Is/was insurance involved: ☐ Yes ☐ No Which company: _____

Insurance name (*if applicable*): Primary _____ Secondary _____

Do you know your chiropractic benefits? ☐ Yes ☐ No Do you have an HSA (*health savings account*)? ☐ Yes ☐ No

Email address: _____

Appointment reminders: ☐ Yes ☐ No If yes, ☐ Text ☐ Email If by text, who is your carrier: _____

Comments: (*office use only*) _____

_____

Spectrum CHIROPRACTIC & HEALTH