Keith Clinic Estramonte Chiropractic

PATIENT INTAKE FORM

Did someone refer you to our office? ☐No ☐Yes If yes, who:______________________________

Were you referred to a specific Doctor? ☐No ☐Yes If yes, Dr.______________________________

SECTION A

Name:__________________ __________________ _____ **Gender**: Male Female

Last First MI

Age:______ **Date of Birth:**__________ **Status**: Married Single Widowed Divorced Separated

Cell Phone #:____________________ **Cell Phone Carrier:**____________________

Home Phone #:____________________ **Best Time to Reach You:**____________________

Address:____ **Apt #:**__________

City:______________________________ **State**:_______ **Zip**:__________

Social Security #: _______-______-_______ **Driver's License #:**____________________

Valid E-Mail Address:____

Employer:________________________ **Employer's Phone #**:____________________

Occupation:____

Employer's Address:____

Street City State Zip Code

Person to Contact in Case of Emergency:______________________________

Relationship:__________________________ **Contact #:** ____________________

SECTION B

PAST HISTORY: Please check any of the following that apply.

☐ Pacemaker

☐ Spinal Surgery

☐ High Blood Pressure

☐ Diabetes

☐ Dizziness

☐ Currently Pregnant

Other history of ***serious health conditions***, ***broken bones*** **or** ***surgeries:*** ☐ N/A

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☐ Take Blood Thinner Medication ____

SECTION C

If your condition is the result of an ACCIDENTAL INJURY within the last 6 WEEKS, please complete the following.

How Did the Accident Occur? ☐ Auto Collision ☐ On-the-Job ☐ Other: ____________________

If injured in an auto collision, please provide the following information:

Date of Accident: ____________________ Driver's Name: ____________________

Property Damage (Amount): ____________________ Location of Accident: ____________________

If applicable, which service(s) responded: ☐ CMPD ☐ Highway Patrol ☐ EMS ☐ Other: ____________________

Did you require post-accident hospitalization? ☐ No ☐ Yes/Hospital Name: ____________________

Have you lost any days from work due to this injury: ☐N ☐Y: ____________ to ____________
Date Date