

CANTON WEST CHIROPRACTIC

New Patient Intake Form

PATIENT INFORMATION

First Name *

Last Name *

Date of Birth

Gender *

Male Female

Phone *

Address (Street, City, State, Zip)

INSURANCE INFORMATION

Insurance Provider

Policy Number

SYMPTOMS & HEALTH HISTORY

Symptoms (Check all that apply): *

- | | | |
|--|--|--|
| <input type="checkbox"/> Personal Injury | <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Arthritis Pain | <input type="checkbox"/> Other |

Health History / Medications / Surgeries:

Conditions History (Check all that apply): *

- | | | |
|--|---|--|
| <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Broken Bones |

LIFESTYLE

Exercise Frequency

Sleep Quality

Stress Level

I certify that the above information is correct to the best of my knowledge. I understand that I am responsible for all charges regardless of insurance coverage.

Patient (or Guardian) Signature

Date