Naas Chiropractic Clinic

New Patient Intake Form

Name: _____

(If Under 18 Years of Age) Name of Parents: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone Number: _____ **Secondary:** _____

E-Mail: _____ **Date of Birth:** _____ (**Age:** _____)

Employer: _____ **Occupation:** _____

Marital Status: Single Married Divorced Widowed

Who do you live with? Spouse Alone Other: _____

Spouses Name: _____ **Spouses Occupation:** _____

Number of Children & Ages: _____

Have You Ever Received Chiropractic Care? Yes No

How did you hear about us? _____

Describe the pain, problem, injury or reason that is bringing you into our clinic: _____

_____

Has this kept you from doing anything you enjoy? **Yes** **No**

What have you been unable to do because of this pain or injury that you would like to be able to do? _____

_____

_____

Did/do you smoke? Yes No **If Yes, For How Long?** _____

Would you like information on the benefits of smoking cessation? Yes, Please! I want to quit! No

Alcohol Consumption: Casual Moderate Heavy / Beer Only Wine Only

How often do you consume caffeine?: Less than 3 drinks daily 3 – 6 drinks daily 6 or More Daily

Do you currently use any recreational drugs: Yes No **How Often:** _____

How often do you exercise? : Never Weekly Daily **Type:** _____

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Vaccinations received in the last year: _____

Major / Significant Illnesses: _____

Hospitalizations: (Surgery, Pregnancy, Surgical Replacements, etc.)

Reason: _____ **Year:** _____ **Hospital:**_____

Reason: _____ **Year:** _____ **Hospital:**_____

Reason: _____ **Year:** _____ **Hospital:**_____

Reason: _____ **Year:** _____ **Hospital:**_____

Are you interested in having your blood analyzed for <u>nutritional</u> deficiencies?

____ Yes! I am interested in having my blood analyzed for nutritional deficiencies so that I may know which vitamins/minerals I can take to improve my health & well-being.

____ Maybe. I'd like more information about what this entails

_____ No. I'm not interested.

Allergies:_____

Medications: (If you have a printed list of medications, feel free to provide us with a copy.)

_____

_____

_____

_____

Height: _____ **Weight:** _____

Patient Signature: _____**Date:** _____