Doble Chiropractic Intake Form

Name: **Date:**

Address:

City **State** **Zip**

Phone **cell** **e-mail**

Date of Birth: **Age** **male** **female**

Married **Single** **Partnered** **No. of Children**

Name of spouse or partner:

Referred to this office by:

Occupation: **Employer:**

Height **Weight**

Purpose of this appointment:

Recent accidents or traumas:

What health problems do you have?

Previous Chiropractic Care:

What do you currently do to maintain your health?

Family physician/phone number

Drugs/Medications currently taking circle (including prescription, non-prescription, over the counter, aspirin, ibuprofen, laxatives, marijuana, nicotine, caffeine: etc.

Have you had any of the following?

Cancer	Neck pain	Vision problems
Diabetes	Arm pain	Bladder dysfunction
Stroke	Leg/hip pain	Chest pain
Rheumatoid arthritis	Numbness extremities	High blood pressure
Heart disease	Tingling extremities	Shortness of breath
Low back pain	Dizziness	Irregular heart beat
Pain between shoulders	Headaches/migraines	Other

Females only: Are you pregnant: yes no not sure

I understand and agreed the amount paid to Doble Chiropractic is for services rendered. I understand that Doble Chiropractic will provide me with billing information to seek reimbursement from my insurance company.

.

_____ _____ Date _____

Signature **Print name**

I authorize Doble Chiropractic to provide care for _____, a minor.

Signature of parent/guardian: _____ Date_____