TRU FORM
CHIROPRACTIC

Patient Intake Form

Date_____

Name_____ What do you prefer to be called? _____

Address_____ City_____

State_____ Zip_____ Age_____ Birthdate_____

Phone: Home_____ Cell_____ Email_____

Occupation_____ Employer_____

Marital Status: S M D W No. of children_____ Spouse's/Partner's name_____

Spouse's/Partner's: Occupation_____ Employer_____

Previous chiropractic care? Y N Name/location of previous chiropractor_____

Date of last adjustment_____ Reason for discontinuing care_____

How were you referred to this office? (person's name, internet, etc)_____

What is your primary concern/complaint regarding your health? _____

List any health conditions you've had or currently have (diabetes, cancer, etc)_____

_____

List any medications/supplements you are currently taking_____

_____

List any surgeries/hospitalizations_____

_____

List any traumas/falls/accidents/fractures_____

_____

Check all symptoms you currently suffer from:

Acid Reflux	Chest Pain	Dizziness	Muscle tension/weakness/spasms
Allergies	Constipation	Ear ringing	Numbness/tingling
Asthma	Depression	Fatigue	Sleep Disorders
Anxiety	Diarrhea	Headaches	Weight Problem
Back Pain	Digestive Disorders	Insomnia	Other_____