VIP * PRACTICE MEMBER INTAKE FORM

Today's Date: _____ Referred By: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State/Zip: _____

Phone: Home (____)_____ Work (____)_____ Cell (____)_____

e-Mail: _____ Work e-Mail: _____

Contact Method (check one): Home Phone ( ) Work Phone ( ) Cell Phone ( ) e-Mail ( ) Work e-Mail ( )

Date of Birth _____ Sex: ( ) Male ( ) Female Social Security #_____

Marital Status (check one) ( ) Single ( ) Married ( ) Divorced ( ) Other

Name Emergency Contact _____

Phone: _____ Relationship: _____

Employment Status (check one)

( ) Employed ( ) FT Student ( ) PT Student ( ) Other ( ) Retired ( ) Self Employed

Employer: _____ Occupation: _____

Primary Insurance: _____

Secondary Insurance: _____

Race (check one)

( ) White ( ) Black/African American ( ) Hispanic ( ) American Indian/Alaskan Native
( ) Asian ( ) Asian Indian ( ) Chinese ( ) Filipino
( ) Japanese ( ) Korean ( ) Vietnamese ( ) Samoan
( ) Guamanian/Chamorro ( ) Native Hawaiian or other Pacific Island ( ) Other _____

Multi-Racial (check one) ( ) Yes ( ) No ( ) Unknown

Ethnicity (check one) ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) I choose not to specify

Preferred Language (check one)

( ) English ( ) Spanish ( ) American Sign Language ( ) Chinese ( ) French ( ) German
( ) Tagalog ( ) Italian ( ) Vietnamese ( ) Korean ( ) Russian ( ) Polish
( ) Arabic ( ) Japanese ( ) Portuguese ( ) Greek ( ) Hindi ( ) Persian
( ) Urdu ( ) Gujarati ( ) French Creole ( ) Armenian ( ) I choose not to specify

Do you smoke tobacco of any kind? ( ) Yes ( ) Former smoker ( ) Never smoked
If yes, how often do you smoke? ( ) Current every day ( ) Currently sometimes
If yes, what is your level of interest in quitting? ( ) No interest ( ) Some interest ( ) Very interested

Have you had an X-ray or CT scan or MRI of your lower back in the past 28 days? ( ) Yes ( ) No

Have you seen a Chiropractor before? ( ) Yes ( ) No

Who? _____ When? _____

Current Medications, including frequency and dosage if know. If none check here: ( )

Medication	Start Date	Medication	Start Date
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

List any known allergies to any medications. If none, check here: ( )

1)		3)	
2)		4)	

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

Rate your pain: (circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Other doctors you have seen for this condition: _____MD _____DC _____DO _____DDS _____Other
Who? _____

When did this condition begin? _____ If accident related, date of accident _____

Which of the following is your condition interfering with: ( ) Work ( ) Sleep ( ) Daily Routine

Has this condition occurred before? ( ) Yes ( ) No

Is condition: Job Related? _____ Auto Accident? _____ Home Injury? _____ Fall? _____

Recent Major Life Changes: _____

_____

How long has it been since you really felt good? _____Days _____Weeks _____Months _____Years

PAST HEALTH CONDITION

Major Surgeries (include date): Appendectomy _____ Tonsillectomy _____ Gall Bladder _____
Hernia _____ Back Surgery _____ Broken Bone(s) _____ Other: _____
Hospitalizations (other than above) _____
Sports Injuries:_____
Other major accidents (from childhood) _____

PORTAL ACCESS

Verification Question (check only one question, then give the answer to that question)

( ) What is the name of your favorite pet? ( ) What was the make of your first car?
( ) In what city were you born? ( ) What is your favorite movie? ( ) When is your anniversary?
( ) What is your mother's maiden name? ( ) What high school did you attend?
( ) On what street did you grow up?

Verification Answer to the above chosen question: _____
(answer must be at least 6 characters long)