CHIROPRACTIC
PATIENT INTAKE FORM

Last Name: ____________________ First Name: _______________ Date: __________

Mailing Address: ____

City: __________________ Province: _____________ Postal Code: _______________

Home Phone: _________________________ Bus. Phone:________________________

Email (Optional):____
For appointment reminders and paperless receipts

Occupation: ________________________ Employer: ___________________________

Date of Birth: ________________ Sex: _______ Marital Status: S M D W Other
Year—Month— Day

Spouse's Name: ____________________________ Children: ____________________

Emergency Contact Name & Number: ____

Alberta Healthcare Number: ____

Referred By: (Circle One) Friend / Family ____________________________________
Name

Family Doctor Massage Therapist Physiotherapist
Phone Book Sign Other

Is this a work related injury? Yes No
Is your visit due to an Motor Vehicle Accident? Yes No

PREVIOUS CHIROPRACTIC CARE:

Name: ______________________________ Telephone:_________________________

Date of Last Treatment: ____

Results: ____

X-rays Taken? Yes No Date: ____________________

MEDICAL DOCTOR:

Name: _________________________________Telephone: ______________________

Address: ____

Date of Last Appointment: ______________Date of Last Physical: ________________