MARGATE
CHIROPRACTIC HEALTH CENTER™

NEW PATIENT INTAKE FORM

Patient File #: _____ **Today's Date: _____ /_____/_____**

PERSONAL INFORMATION:

Name: (*First*)_____ (*Middle Initial*)_____(*Last*)_____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____ Age: _____ Marital Status (*Circle*): Divorced Married Single Separated Widowed

Do you have children? ☐ Yes ☐ No If yes, # of children _____

Gender (*Circle*): Male / Female Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security #: _____-_____-_____ Email Address: _____

Employer /Employment Status ☐Employed ☐Unemployed ☐Full Time / ☐Part Time Student ☐Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (_____) _____-_____ Type of Work:_____

Is it ok to contact you at work? ☐ Yes ☐ No

Emergency Contact Information

Name: (*First*)_____ (*Middle Initial*)_____(*Last*)_____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

☐ Yes ☐ No

Who besides yourself is responsible for your bill?

☐Self-Pay ☐Health Insurance ☐Medicare ☐Medicaid ☐ Worker's Comp ☐Auto Insurance

☐ Other (*Be Specific*): _____

Auto or Workers' Comp Insurance Carrier & Claim #: _____

COMPLAINTS:	**WHEN DID IT START?**
1.	
2.	
3.	
4.	
5.	
6.	

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LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____

_____

_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____

_____

_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

_____

_____

_____

ASSOCIATED Complaints:

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Nausea/vomiting	☐Yes	☐No			
Headaches	☐Yes	☐No			

☐ Depression ☐ Nervousness ☐ Fatigue ☐ Anxiety ☐ Excessive irritability
☐ Fear of driving in a car ☐ Loss of concentration ☐ Jaw clenching ☐ Dizziness
☐Nightmares

Numbness/Tingling:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins. I understand and agree that this office has the right to terminate my care as a patient if I do not follow the prescribed treatment for my condition. I understand and agree that I might be referred to another health provider as the doctor deems medically necessary.

_____ _____

PATIENT PRINTED NAME **PATIENT SIGNATURE**

_____

DATE