Long Chiropractic Center

Dr. Lara and Dr. Rebecca Long

PATIENT INTAKE FORM

Date:			
PATIENT INFORMATION			
Last Name: First Name: Middle:			Marital Status (please check one): ❑ Single ❑ Married ❑ Divorced ❑ Partner
Birth Date:	Age:		Email Address:
Do you have children? ❑ Yes ❑ No (If yes, please provide their name(s), age(s), and any health issues:			
Street address:		Home Phone #: ( )	Mobile phone #: ( )
P.O. Box/Unit #:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone #: ( )
How did you find out about us? (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages ❑ Word of Mouth
If someone referred you, who?			

REASON FOR VISIT			
❑ General	❑ Car Accident	❑ Work Injury	❑ Other Accident

INSURANCE INFORMATION
Do you have insurance? ❑ Yes ❑ No (if yes, please give your insurance card and photo I.D. to front desk)

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

PRESENT COMPLAINTS		
1.		How long?
2.		How long?
3.		How long?
Have you received other treatment for these conditions?	❑ Yes ❑ No	
If yes, who and where?		

PREVIOUS ACCIDENTS/INJURYS		
Past Auto Accidents? ❑ Yes ❑ No	How recent?	Treatment? ❑ Yes ❑ No
Past work injury? ❑ Yes ❑ No	How recent?	Treatment? ❑ Yes ❑ No
Other injuries? ❑ Yes ❑ No	How recent?	Treatment? ❑ Yes ❑ No

FAMILY HISTORY		
NAME	**PRESENT SYMPTOMS**	**PREVIOUS ILLNESS**
Date of last menstrual cycle:	Are you pregnant? ❑ Yes ❑ No	

GENERAL SYMPTOMS		
(Circle any you currently have or have had in the past year.)		
❑ Headache: Sinus/Tension/Migraine	❑ Visual Problems	❑Pain Between Shoulders
❑Dizziness	❑Hearing Problems	❑ Muscle Spasms
❑ Allergies	❑ Ear Infections	❑ Hip Pain
❑Asthma	❑ Loss of Sleep	❑ Sciatica
❑ Numbness of Pain in: Arms/Hands/Legs/Feet	❑ Neck Pain	❑ Difficulty Breathing
❑ Neck Stiffness	❑ Back Pain	❑ Digestive Problems
❑ Menstrual Problems		

I hereby state that the above information is true to the best of my knowledge. I authorize Long Chiropractic Center to examine, take x-rays, treat me, and do whatever they deem necessary in accordance with the state statues for the care and management of my condition(s). I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and me. I understand that I am financially responsible for any balance, and that any amount authorized to be paid directly to Long Chiropractic Center will be credited to my account on receipt. I also authorize Long or insurance company to release any information required to process my claims. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian signature *Date*