THE GILBERT CLINIC
Chiropractic – Massage – Core Concepts

**Patient Intake Form** Date: _____

## Patient Information

Full Name: _____
First MI Last (name you like to be called by)

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

Age: _____ Birth Date: _____ Female: _____ Male: _____ Social Security Number: _____

Email Address: _____

**I am (circle)** -- Under 18 / Single / Married / Divorced / Widowed / Separated

Home Phone: _____ Work Phone: _____ Cell/Other: _____

**I prefer to receive calls at (circle)** Home / Work / Cell / Email / Text

Employer: _____ Occupation: _____

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

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Other Doctor seen for this condition: Name: _____ ☐ M.D. ☐ Chiropractor

What type of treatment have you received for this condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None

Have you been to a Chiropractor in the past? ☐ No ☐ Yes _____ Date of last visit: _____

Whom may we thank for referring you? (circle) patient / friend / neighbor / other _____
Name

Where have you heard about us? (circle) Voice / Times Herald / Local Ad / Internet / Billboard / Sign-Location / Web-Site

Name of Family Physician: _____ Address: _____

Your Password for the new electronic records will be your initials and birthdate:

_____ _____

First Initial Middle Initial Last Initial MM/DD/YY Your Password

**Smoking Status?**

□ Current every day smoker

□ Current some day smoker

□ Former smoker

□ Never smoker

**Do you have any medication allergies?**

□ No known medication allergies

□ Yes. Please list:

_____ _____

_____ _____

**Are you currently taking any medications?**

□ Not currently prescribed any medications

□ Yes… Please list: (If you have a list, we can copy it for you)

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

---------- *Office use only* ----------

W _____ H _____ BP _____ P _____