

# Naas Chiropractic Clinic

## New Patient Intake Form

Name: \_\_\_\_\_ Preferred Pronouns \_\_\_\_\_

(If Under 18 Years of Age) Name of Parents: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (Age: \_\_\_\_\_)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Who do you live with?  Spouse  Alone Other: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Spouses Occupation: \_\_\_\_\_

Number of Children & Ages: \_\_\_\_\_

Have You Ever Received Chiropractic Care?  Yes  No

How did you hear about us? \_\_\_\_\_

Describe the pain, problem, injury or reason that is bringing you into our clinic: \_\_\_\_\_

Has this kept you from doing anything you enjoy?  Yes  No

What have you been unable to do because of this pain or injury that you would like to be able to do?

Smoking History:  Never  Former  Current If Yes, For How Long? \_\_\_\_\_

Alcohol Consumption:  Casual  Moderate  Heavy /  Beer Only  Wine Only

Do you consume caffeine?:  No  Less than 3 drinks daily  3 - 6 drinks daily  6 or More Daily

Do you currently use any recreational drugs:  Yes  No How Often: \_\_\_\_\_

How often do you exercise?:  Never  Weekly  Daily Type: \_\_\_\_\_

**Vaccinations received in the last year:** \_\_\_\_\_

**Major / Significant Illnesses:** \_\_\_\_\_

**Hospitalizations:** (Surgery, Pregnancy, Surgical Replacements, etc.)

**Reason:** \_\_\_\_\_ **Year:** \_\_\_\_\_ **Hospital:** \_\_\_\_\_

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**Are you interested in having your blood analyzed for nutritional deficiencies?**

\_\_\_\_ **Yes!** I am interested in having my blood analyzed for nutritional deficiencies so that I may know which vitamins/minerals I can take to improve my health & well-being.

\_\_\_\_ **Maybe.** I'd like more information about what this entails

\_\_\_\_ **No.** I'm not interested.

**Allergies:** \_\_\_\_\_

**Medications:** (If you have a printed list of medications, feel free to provide us with a copy.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_