CHIROsport & Spine
421 E. Main Street
Endicott, NY 13760
PH: (607) 321-7674
Fax: (607) 239-6772

PATIENT INTAKE FORM

Name: _____ Nickname: _____

Date of Birth: _____ Age: ____ Gender: (*circle one*) male female

Address: _____City: _____ State: _____Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____ ext_____

Email: _____

What is the best way to contact you? *(circle one)* Phones: Home Cell Work Email Text

Marital Status:(*circle one)* Single Married Divorced Separated Other:_____

Children:(*circle one*) Yes/No How Many?_____ Ages:_____

Employment Status: (*circle one)* Employed FT Student PT Student Retired Disabled

Occupation: _____ Employer: _____

Primary Care Physician:_____ Location:_____

Would you like our office to communicate your condition and course of care with your PCP? (*circle one)*

Yes No

Have you ever had chiropractic care? Yes No When was your last treatment?: _____

What were you being treated for: _____

Has any of your family received chiropractic care? Yes No

How did you hear about us?

- ☐ Patient Referral, who can we thank? _____
- ☐ Dr Referral: Dr's Name: _____
- ☐ Facebook
- ☐ Webpage
- ☐ Other: _____

1. Emergency contact: _____ Phone: _____ Relationship: _____
2. Emergency contact: _____ Phone: _____ Relationship: _____

Patient's Signature: _____ Date: _____