

MILWAUKIE WELLNESS CENTER
CONFIDENTIAL CHIROPRACTIC INTAKE FORM

PLEASE PRINT CLEARLY

Name _____ Mid. _____ Last _____

Address _____ City _____

State _____ Zip _____ Social Security No. _____ Birthdate _____

Work Phone _____ Home Phone _____ Cell _____

Employer _____ Address _____

Marital Status _____ Spouse's Name _____

Driver's License Number _____ State _____

Emergency Contact _____ Phone _____

Would you like to be included on our email list? E-mail Address: _____

Briefly describe your symptoms _____

Previous Treatment or X-Rays for this condition (when & where) _____

PLEASE LIST YOUR COMPLETE MEDICAL HISTORY INCLUDING:

Fractures/Dislocations _____ When _____

Surgeries _____ When _____

Cancer _____ When _____

Recent Accidents, Injuries or Illness _____

Other _____

Are You Taking Any Medications? YES/NO If so, what kind? _____

Women, are you pregnant? YES/NO First day of last menstrual period? _____

I understand that as a courtesy to me, this office will bill my insurance company directly; I still remain financially responsible for all charges. I instruct my insurance company to pay this office directly for all services and authorize the release of any information necessary to secure payment. I hereby authorize the doctor and the designated assistants, to administer treatment as deemed necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's or
Guardian's Signature _____ Date _____