Foster Chiropractic

New Patient Digital Intake Form

Patient Information

Date	
First Name	
Last Name	
Date of Birth	
Age	
Current Weight	
Gender	
Address	
City	
State	
ZIP Code	
Email Address	
Cell Phone	
Home Phone	
Occupation	
Employer	
Employer Address	
Marital Status	
Emergency Contact Name	
Emergency Contact Relationship	
Emergency Contact Phone	

Insurance Information

Primary Insurance Company	
Member ID Number	
Policy Holder Name	
Policy Holder Date of Birth	
Secondary Insurance Company (if applicable)	
Secondary Member ID Number	

How Did You Hear About Us?

☐Google Search ☐Website ☐Facebook ☐Friend/Family ☐Physician Referral ☐Other

Current Condition

Primary Reason for Visit:

_____

How Did the Condition Start?:

_____

When Did It Start?:

_____

Medical Conditions:

_____

Previous Surgeries:

_____

Current Medications:

_____

Major Accidents or Injuries:

_____

Pain Level (0-10): _____

Type of Pain: ☐Sharp ☐Dull ☐Aching ☐Burning ☐Tingling ☐Numbness ☐Shooting ☐ Other

Interferes With: ☐Work ☐Sleep ☐Daily Activities ☐Exercise ☐Recreation

Painful Activities: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Health History

Please check any that apply:

☐Heart Disease ☐High Blood Pressure ☐Diabetes ☐Pacemaker

☐Metal Implants ☐Cancer/Tumors ☐Bleeding Disorders ☐Arthritis

☐Osteoporosis ☐Stroke ☐Pregnancy ☐Other

Communication Preferences

Appointment reminders by: ☐Text Message ☐Email ☐Phone Call

I consent to receive appointment reminders and office communications. ☐Yes ☐No

Acknowledgements

I certify that the information provided is accurate and complete to the best of my knowledge.

I understand that treatment recommendations are based on information I provide.

I authorize Foster Chiropractic to communicate with me regarding appointments and care.

Patient Signature: _____

Date: _____