

Chiropractic Client Intake Form

Thank you for your interest in being a client of Dr. Raymond E. Stricker.
Information collected about new patients is confidential and will be treated accordingly.

Patient Details

Patient Name: _____ Date of Birth: __/__/____
SSN: _____ Sex: Male _____ Female _____
Street Address: _____
City: _____ State _____ Zip Code _____
Home Phone: _____ Cell Phone: _____
Email: _____
How did you hear about us? _____
Marital Status: ____ Single ____ Married (Spouse's Name: _____)
Have you been to a chiropractor before?: ____ Yes ____ No
*If so, how long ago? _____ Where? _____

Emergency Contact Information

Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

Symptoms

List the areas on your body where you experience pain: _____

How long ago did your symptoms begin? _____
What makes your symptoms better? _____
What makes your symptoms worse? _____
Is this problem related to a work injury? ____ car accident? ____ or personal injury? ____
Is this an old injury? _____ or is this a new injury? _____