Chiropractic Center of New Britain
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# NEW PATIENT INTAKE FORM

Name (First): (Last):

Address: Apt Number:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Date of Birth: Age: Sex: M F

Social Security Number: E-mail Address:

Occupation: Employer:

Marital Status: M S D W

**Race:** ☐ American Indian *or* Alaskan Native ☐ Asian ☐ Black *or* African American ☐ Caucasian ☐ Native Hawaiian *or* Pacific Islander ☐ Hispanic *and/or* Latino
☐ Decline to answer ☐ Other: _____

Preferred Language: _____

Have you ever received Chiropractic Care? YES NO If ***YES***, When? :

Name of recent Chiropractor:

Referred by:

Is this visit the result of a work or auto injury? YES NO

**Reason for seeking Chiropractic Care today:**

Primary Reason:

Secondary Reason:

**Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s) as to why you are here today :**

# PAST HEALTH HISTORY

***Allergies:***

***Medications:***

| Medication | Reason for Taking |
|---|---|
| | |
| | |
| | |

***Surgeries:***

| Surgery Date | Type of Surgery |
|---|---|
| | |
| | |

***Females / Pregnancies & Outcomes:***

| Pregnancies / Date of Delivery | Outcome |
|---|---|
| | |
| | |

***Family Health History:***

Do you have a family history of? (please indicate all that apply)

☐ Cancer ☐ Stroke / TIA ☐ Headaches ☐ Neurological Diseases ☐ Psychiatric Disorder
☐ Diabetes ☐ Cardiac Disease ☐ Adopted / Unknown ☐ Cardiac Disease before age 40 ☐ None of the above
☐ Other: _____

***Deaths in the immediate family:***

| Family member | Cause of death |
|---|---|
| | |
| | |

***Social History:***

Do you smoke or use tobacco products? :

☐ Never ☐ Past - When did you stop? _____ ☐ Present – When did you start? _____

Number of cigarettes each day _____

Any recreational drug use? YES NO How much _____ How often _____

Do you drink alcohol? YES NO How much _____ How often _____