

Patient Information :: Intake Form :: Healing Waters Clinic
Confidential-Please Print Clearly

Name _____ Date _____.

Phone: Home _____ Work _____ Cell _____

Local Address _____ City _____

State _____ Zip Code _____

2nd Address (Out of State) _____ City _____

State _____ Zip Code _____

Date of Birth _____ Age _____ M _____ F _____ Marital Status _____

No. of children _____ Occupation _____

Are you pregnant? _____ Which trimester _____ Due date _____

Name of attending or primary physician _____

Other doctors (include chiropractors, specialists, etc.) _____

Have you been in a car accident? _____ Do you have a lawyer? _____

Referred by _____

Check any that apply-how did you find us? Internet _____ Drive By _____ Advertisement _____

Your e-mail _____ Are you on Facebook? _____

Present Symptoms: What is your major complaint? _____

Minor Complaints: Other areas of pain or concern _____

Do you have a medical diagnosis? List all conditions: _____

Have you received medical or alternative treatment for the major complaint? _____ If so, what kind _____

When did you first notice major complaint? _____

Do you have Scar Tissue? _____

Have you ever had any operations? Yes _____ No _____ Broken bones? _____

Have you ever been in an car accident or had traumatic injury? Yes _____ No _____ More than one? How many? _____