

Patient Intake Form -

Patient Information

____/____/____
Today's Date

Last Name

First Name

MI

____/____/____
Date of Birth

Street Address

City

State

Zip

Home Phone

Cell Phone

Work Phone

Email Address

Referred by

Other family members seen here

Emergency Contact

Relationship

Phone Number

Reason for

Please describe any specific issues or pain and its location

Health

Please describe your general health and list any medical conditions

Current Medications

Allergies

Consent

I authorize Greenlee Chiropractic & Acupuncture Clinic Inc to perform massage therapies. I also agree to pay for said services. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.

Signature

Date