Chiropractic Center of New Britain

Dr. Francis J. Vesci, D.C.

INTAKE FORM

Date: _____

PLEASE DO NOT LEAVE SECTIONS BLANK WITH (*) NEXT TO THEM.

*Name (First): * (Last): * (Middle):

*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: _____

***EMERGENCY CONTACT INFORMATION:**

*Full Name: _____ *Relationship: _____

*Phone Number: _____

***INSURANCE INFORMATION:** ☐ **HealthCare Insurance** ☐ **Self-Pay / No Insurance**

Name of Insurance: _____

☐ **Medicare**

☐ I am the Subscriber

☐ I am **NOT** the Subscriber

If your billing address is different OR you are not the Subscriber, please fill the bottom section accordingly:

Subscriber Name: Last: Middle:

Relationship: Date of Birth: Phone No:

Address: City/State: Zip Code:

*Have you ever received Chiropractic Care? ☐ **YES** ☐ **NO** If *YES*, when? _____

Name of Chiropractor: _____

*Were you referred by a friend or family member? ☐ **YES** ☐ **NO**

If *YES*, name of patient(s) who referred you: _____

If *NO*, where did you hear about us? _____

***Reason for seeking Chiropractic Care today:**

Primary Reason: _____

Secondary Reason: _____

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

HEALTH HISTORY

*__Have you sought any previous interventions, treatments, medications, surgery, or care to help you with why you are here today?__

*__High Blood Pressure?__ ☐YES ☐NO If yes, what was your last reading?

*__Allergies:__

*__Medications:__

Medication	Reason for Taking

*__Surgeries:__

Surgery Date	Type of Surgery

__FEMALES ONLY – Pregnancies & Outcomes:__

Pregnancies / Date of Delivery	Outcome

__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 _____

*__Do you use recreational drugs?__ YES NO How much _____ How often _____

*__Do you drink alcohol?__ YES NO How much _____ How often _____

__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