



# Milton Chiropractic & Rehabilitation, Inc.



# BAY STATE PHYSICAL THERAPY

## General Patient Intake Form

File Number (Office Use) \_\_\_\_\_

### Patient Information:

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Sex  Male  Female

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

If minor, name of parent or guardian \_\_\_\_\_

Who should we contact in case of an emergency? \_\_\_\_\_

Relation \_\_\_\_\_

Address \_\_\_\_\_

Attorney \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

» Is He/She within Harvard Vanguard Medical Group  YES  NO

How did you hear about our office? \_\_\_\_\_

Have you ever been to a chiropractor before?  YES  NO If so, whom? \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

Height \_\_\_\_' \_\_\_\_" Weight \_\_\_\_ lbs

Marital Status \_\_\_\_\_

No of Children \_\_\_\_\_

### Insurance Information:

Insurance Company \_\_\_\_\_

Ins Co. Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relation \_\_\_\_\_

Policy number \_\_\_\_\_

Ins Co. Phone \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

### Reason for Visit:

This visit is as a result of (*Please circle*): **work, sports, auto, trauma, or chronic**

Please describe your pain and its location \_\_\_\_\_  
\_\_\_\_\_

Please describe what happened \_\_\_\_\_  
\_\_\_\_\_

When did the symptoms begin? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is the condition getting worse?  YES  NO  CONSTANT  COMES & GOES

Is your condition affecting your  WORK  SLEEP or  DAILY ROUTINE?

Please explain \_\_\_\_\_

Have you had this or similar conditions in the past?  YES  NO

Please explain \_\_\_\_\_

Have you been treated by a medical physician for this condition?  YES  NO

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_