Dr. Kenneth D. Carle

Carle Chiropractic Clinic
Intake Form

Date_____

Name_____Age_____Date of Birth_____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Employed by_____SS#_____

Referred By_____

E-Mail address_____

Marital Status_____Spouses Name_____

Emergency Contact_____Phone #_____

Have you ever had Chiropractic care before? _____yes _____no

If so when? _____ Name of previous Chiropractor_____

Are you here as a result of an auto accident? _____ If so, date of accident_____

Who is responsible for your bill? _____Self ____Other (list)_____

Type of Insurance

_____None _____Health Insurance _____Medicare _____Auto Insurance _____Worker's Comp

Name of Company_____

Most insurance will cover part or all of your expenses.
We may accept assignment only after we verify your policy coverage.

Major Complaint:

_____

_____

_____

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____ ❒male ❒female DOB:_____

Home Phone:_____ Zip Code:_____

Preferred Language?
- ❒ **English**
- ❒ **Spanish**
- ❒ **Other_____**

Race?
- ❒ **I do not wish to provide this information.**
- ❒ **White**
- ❒ **Black or African American**
- ❒ **American Indian or Alaska Native**
- ❒ **Asian**
- ❒ **Native Hawaiian or Other Pacific Islander**
- ❒ **Other_____**

Ethnicity?
- ❒ **I do not wish to provide this information**
- ❒ **Hispanic or Latino**
- ❒ **Non-Hispanic or Non-Latino**
- ❒ **Other_____**

Smoking Status?
- ❒ **Current every day smoker**
- ❒ **Current some day smoker**
- ❒ **Former smoker**
- ❒ **Never smoker**

Is your blood pressure
- ❒ **Low/Normal**
- ❒ **Normal**
- ❒ **High**
- ❒ **On medication for Blood Pressure**

What is your height?_____ What is your weight?_____

Do you have any medication allergies?
- ❒ **No known medication allergies**
- ❒ **Yes. What? _____**

Are you currently taking any medications?
- ❒ **Not currently prescribed any medications**
- ❒ **Yes….**

What?_____Dose:_____Form:_____How Often:_____
What?_____Dose:_____Form:_____How Often:_____
What?_____Dose:_____Form:_____How Often:_____