Patient Intake Form
Klug Chiropractic 715-832-2292
2130 Brackett Ave. Eau Claire WI 54701
James Klug DC

Date ____/____/_____

CASH / MEDICARE / INSURANCE COMPANY NAME _____

PERSONAL INFORMATION

LAST NAME: _____ FIRST: _____ M.I _____

GENDER: MALE / FEMALE BIRTHDAY: _____/_____/_____ AGE: _____ HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: SINGLE / MARRIED SPOUSES NAME _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRED BY: INTERNET / FAMILY / FRIEND NAME: _____

PREVIOUS CHIROPRACTIC CARE: Y / N APPROX DATE: _____ WHERE: _____

CONTACT INFORMATION

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

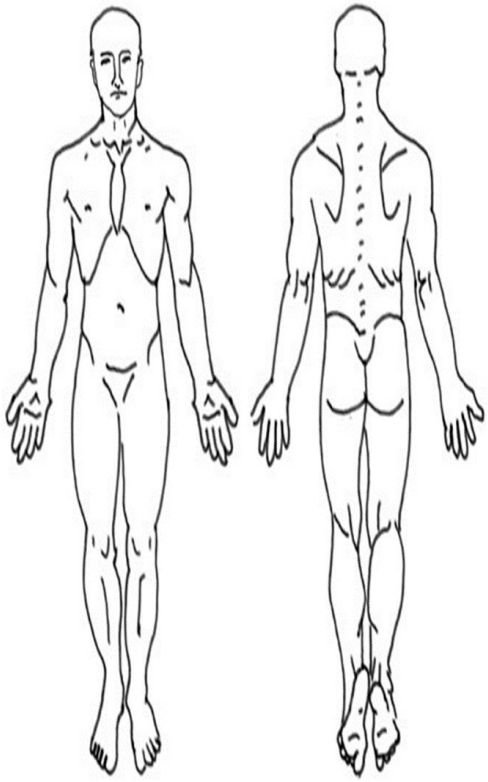
CELL PHONE: _____ HOME: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

EMPLOYER PHONE: _____

PLEASE CIRCLE WHERE YOU HURT BELOW:



CONDITION INFORMATION

REASON FOR VISIT: _____

ACCIDENT RELATED: Y / N AUTO / WORK / PERSONAL INJURY

DATE OF INJURY: _____

DATE SYMPTONS STARTED: _____

RATE PAIN 0-10: _____ PAIN IS: CONSTANT / COMES AND GOES

SHARP / DULL / BURNING / CRAMPING / THROBBING / RADIATING

INTERFERES WITH: WORK / SLEEP / DAILY ROUTINE / RECREATION

THANK YOU,
WELCOME TO OUR OFFICE

SIGNATURE_____