Patient Intake | Massage Therapy

THOMPSON
CHIROPRACTIC

Please have this form filled out prior to your first visit. All information is strictly confidential.

CURRENT DATE

LAST NAME | FIRST NAME | INITIAL

AGE | DATE OF BIRTH | SEX | MARITAL STATUS | SSN *

ADDRESS

CITY | STATE | ZIP CODE

EMAIL ADDRESS | HOME PHONE | MOBILE PHONE

EMPLOYER | OCCUPATION

WORK ADDRESS

WORK EMAIL ADDRESS | WORK PHONE

EMERGENCY CONTACT | EMERGENCY EMAIL

EMERGENCY HOME PHONE | EMERGENCY MOBILE PHONE | EMERGENCY WORK PHONE

PRIMARY CARE PROVIDER

INSURED'S NAME | INSURED'S DATE OF BIRTH

DATE OF INJURY | CLAIM #

IS THIS CONDITION THE RESULT OF AN ACCIDENT OR INJURY? ☐ WORK ☐ AUTO ☐ OTHER

We are unable to bill auto or L&I without a claim number.
If you do not have the necessary information, payment is expected at time of service. Treatment for injury due to an accident requires a Doctor's Prescription.

* *Required for all First Choice Health Subscribers*

YOUR PRIMARY REASON FOR YOUR VISIT, WITH DATE OF ONSET:

ANY SECONDARY REASONS FOR VISIT, WITH DATE OF ONSET:

Health History

PAST MEDICAL HISTORY (ILLNESSES, MAJOR INFECTIONS, INJURIES, HOSPITALIZATIONS, AND SURGERIES)

Please include dates

MEDICATIONS (PRESCRIBED, OVER THE COUNTER, HERBS, VITAMINS AND SUPPLEMENTS)

Please list dates and reason for taking

I am responsible for paying any and all services if my insurance fails to pay.

Co-payment is due at time of service. $15.00 charge for all no-show appointments.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE