# Hulse Family Chiropractic

Intake Form

## Personal Information

**First Name**_____**Middle**_____**Last**_____

**Home Street Address**_____

**City**_____**State**_____**Zipcode**_____

**Cell Number**_____**Home Number**(if different)_____

**Email Address**_____

**Date of Birth**_____**Sex**: **M**_____**F**_____

**Status:** Single_____Married_____Divorced_____Widowed_____Other_____

**Social Security Number**_____**Referred by**_____

**Status:** In School_____Employed_____Stay Home_____Retired_____

**Employer Name**:_____

## **If patient is a minor, who is responsible for services rendered:

**Contact Name:**_____**Contact Phone:**_____

## Insurance Information

**Primary Insurance Carrier**_____

**Secondary Insurance Carrier** (if applicable)_____

**Insured's Name**_____**Insured's Date of Birth**_____
**Relationship to Insured** (choose 1): Self_____Spouse_____Child_____

**(Flip Over)**

**Reason For Your Visit Today** (Please explain below)

_____

_____

_____

_____

**When did your condition begin?**_____

**Have you received Chiropractic care before**?_____

Where_____When_____

****Surgeries, Spinal Surgeries or Cosmetic Surgeries** (list all including any implants)

_____

_____

_____

**Describe your pain**: Ache_____Burning_____Numbness_____Pins & Needles_____

Dull_____Sharp_____Stabbing_____Other (explain)_____

**Is this condition due to an Auto Accident or Work Related Injury**?_____

****If so, ask receptionist for additional paperwork****

*I hereby assign to and authorize payment directly to Hulse Chiropractic for benefits payable from my Insurance Companies for services rendered to me or my child/children. I realize that Insurance, Workman's Compensation, Auto Accident Claims, or Liability Claims may not cover all of the services rendered to meor anyone under my authority and I agree to pay any difference or balance due if necessary.

_____ _____

**Signature** **Date**