BAC Clinic of Chiropractic ***Intake Form*** **1501 Nebraska St.**

Initial Call Date:_____ Appt. with: □ Dr. Brad Chicoine
□ Dr. Jennifer Chicoine
□ Dr. Nick Chicoine

Today's Date: _____ Signature of Patient:_____

First Name: _____ Last Name:_____ Middle:_____

Address: _____City:_____ State:_____ ZIP:_____

Home Phone: _____ Work Phone:_____

Cell Phone:_____ E-mail address:_____

Preferred Contact method: ***(Please Check)***

Home Phone_____ Work Phone_____ Cell Phone_____ E-mail____

Date of Birth: _____ Age: _____ Marital Status: M S W D

Social Security #_____

Occupation: _____ Employer: _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS #_____

Spouse's Occupation: _____ Spouse's Employer: _____

EXISTING PATIENTS BEGIN HERE

Race: ***(Please Check)***

____White _____Black/African American _____Hispanic _____ Other

Ethnicity: ***(Please Check)***

____Hispanic or Latino ____Not Hispanic or Latino ____I choose not to specify

Preferred Language: ***(Please Check)***

____English ____Spanish ____ French ____Chinese ____Vietnamese ____Other

Please choose a password:_____

Verification Question *(Choose only one by circling the question, then give the answer to that question)*

- What is the name of your pet?
- In what city were you born?
- In what city did you attend high school?

Verification Answer to the chosen question:_____

Please Continue on the Back Side

Current medications, include frequency and dosage if known and reason for taking:

Name & Dosage **Reason**

1)_____/_____

2)_____/_____

3)_____/_____

List any allergies: ☐ Animals ☐ Aspirin ☐Bees ☐ Penicillin ☐Ragweed/Pollen ☐Shellfish ☐Dust ☐ Dairy ☐Seasonal Allergies ☐None ☐ Other:_____

Do you take vitamins or supplements? ☐ Yes ☐ No **If Yes, Please List**:_____

Briefly list your main health problems:_____
_____

Have you had any past surgeries/operations? ☐ Yes ☐ No

If yes, please list all:_____

Do you have a history of the following health conditions?

☐ Ankle Pain	☐ Arm Pain	☐Arthritis	☐Asthma	☐Back Pain	☐ Fractures
☐ Cancer	☐Diabetes	☐ Epilepsy	☐Fatigue	☐Headaches	☐ Hip Pain
☐ High Blood Pressure		☐ Knee/Leg pain		☐ Multiple Sclerosis	
☐Neck Pain	☐ Parkinson's	☐ Polio	☐Shoulder pain	☐ Stroke/Heart Attack	

Have you had any of the following disease? ☐Measles ☐Mumps ☐Chicken Pox ☐Other_____

Do you know of any adult disease you may have? ☐ Yes ☐ No
If yes, please explain:_____

Have you ever been hospitalized? ☐Yes ☐ No
If yes, please explain:_____

Have you had any major accidents, falls or injuries? ☐Yes ☐No
If yes, please explain:_____

Do you currently smoke tobacco of any kind?
☐Yes **☐Former Smoker** **☐Never been a Smoker**

Do you drink alcohol? ☐ Yes ☐ No **If yes, how often?** ☐ Occasional ☐ Social ☐ Frequently

Do you exercise? ☐ Yes ☐ No **If yes, how often?** _____times per week _____times per month

Do you get adequate sleep or rest at night? ☐ Yes ☐ No **Approximate hours per night?**_____

Please list the date of your last physical examination by medical doctor _____
Where there abnormal findings? ☐Yes ☐ No **If yes, please explain** _____

To be performed by clinic staff:

Height:_____ Weight:_____ BP:_____/_____