NP

Carle Chiropractic Clinic

Dr. Kenneth D. Carle

Intake Form

Date _____

Name _____ Age ____ Date Of Birth _____

Address _____ City _____ State ___ Zip _____

Cell Phone _____ E-mail _____

Referred by _____

Marital Status ____ Spouse _____

Have you had Chiropractic care before? ____

If so, when? _____ Name of Treating Dr _____

Smoking Status (circle one)

Current-daily / Current-some / Former smoker / Never smoked

Height ____ Weight _____ Blood Pressure (circle one)

Low / Normal / High / On meds

Insurance? ____ Name _____

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

Major Complaint _____

_____

_____

_____

_____

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