

Patient Information Intake Form



Mankey Family
Chiropractic

Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Personal Info:

Last Name: _____ First Name: _____ Middle Initial: _____
DOB: _____ Gender: M / F SSN: _____
Weight: _____ Height: _____ Name Suffix: Jr. / Sr.
Marital Status: M / S / W / D Employed: Yes No Title: _____
Preferred Language: Eng Span Smoker? Never Former Current Frequency: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Fax: _____ Preferred Phone: Cell Home
Email: _____ Reminder: Emails Texts Neither
How did you hear about us? _____ (For text reminders) Verizon AT&T
If referred by friend, can we send them a thank you? Yes No Other _____

Employment Info:

Employer Name: _____ Employer Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact Info: (Check "same" if the address is the same as yours)

Contact Name: _____ Relationship to Patient: _____
Address (Same): _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Info: (omit if not going through insurance)

Primary Insurance Carrier _____
Primary Insured Name _____ Relationship: Self Spouse Child Other
Secondary Insurance Carrier _____
Secondary Insured Name _____ Relationship: Self Spouse Child Other

Accident/Injury:

Was this injury/illness caused by: Work Accident? Auto Accident? Other
Date of Accident _____ Dates missed from work _____
Are you receiving any litigation for your injury/illness? Yes No
Are you receiving any litigation for any other injuries/illnesses? Yes No

Previous Care:

Have you ever been treated by a chiropractor? Yes No Date of last Appt: _____

For Office Use Only: G CP MC