

Sandia View Wellness
4101 Barbara Loop SE, Suite D
Rio Rancho, NM 87124
(505)891-2667
SVWell.com

New Patient Intake Form

(Confidential – For Office Use Only)

Date: _____

Personal Information

Full Name: _____

Preferred Name (if different): _____

Date of Birth: _____ Age: _____ Gender: Male Female Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:

Email Address: _____

Marital Status: Single Married Partnered Divorced Separated

Widowed

Emergency Contact Name: _____

Relationship: _____

Emergency Contact Phone: _____

Employment Information

Occupation: _____

Employer/School: _____

Type of Work (e.g., desk, physical, driving):

Employer Address:

How did you hear about Sandia View Wellness? (e.g., referral, website, Google, friend):

Primary Reason for Visit:

What is the main reason you are seeking chiropractic care today?

When did your current symptoms/condition begin? _____

Have you experienced this before? Yes No (If yes, when?
_____)

Please describe your symptoms (e.g., (P)=pain, (S)=stiffness, (N)=numbness,
(T)=tingling, (W)=weakness, (HA=)headaches):

On a scale of 0–10 (0 = no pain, 10 = worst imaginable), rate your current discomfort
level: _____

What makes it better?

What makes it worse?

Does it interfere with: Work Sleep Daily activities Driving Other:

Please mark areas of pain/discomfort on the body diagram below (or describe):

Motor Vehicle Accident (MVA) Section

Are you seeking care today as a result of a motor vehicle accident? Yes No

If No, skip to the next section (Health History).

If Yes, please provide details:

Date of Accident: _____ Time: _____ AM PM

Location of Accident:

Were you the: Driver Passenger (front/rear) Pedestrian Other

Were you wearing a seatbelt? Yes No

Describe how the accident occurred (direction of impact, speed, etc.):

Insurance and Claim Information (Required if MVA-related)

Do you have medical/health insurance? Yes No

Insurance Company: _____ Policy/ID #:

Group #: _____ Policy Holder Name:

Do you have an auto insurance claim for this accident? Yes No

Your Auto Insurance Company:

Policy #: _____ Claim #:

Adjuster Name: _____ Phone:

Other Vehicle's Insurance Company (if known):

Policy #: _____ Claim #:

Have you retained an attorney for this accident? Yes No

Attorney Name: _____ Firm:

Attorney Phone: _____ Email:

May we contact your attorney to coordinate care? Yes No

Health History:

Past Surgeries (list with dates):

Significant Injuries/Traumas (e.g., previous accidents, falls):

Current Medications (include dosage and purpose):

Allergies (medications, foods, etc.):

Major Illnesses or Conditions (e.g., diabetes, heart disease, arthritis, cancer):

Have you ever received chiropractic care before? Yes No

If yes, when and with whom?

What did you like/dislike about previous care?

Family Health History (if relevant to your condition):

Consent and Signature

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that Sandia View Wellness may use this information to provide care, coordinate with insurance/auto claims (if applicable), and for billing purposes.

***Please have your drivers license/ID and medical insurance card, if needed, ready at the first appointment.*

Patient Signature (or Guardian if minor): _____

Date: _____