# AVON CHIROPRACTIC

## New Patient Intake Form

### Patient Information

First Name: _____ M.I. ____ Last Name: _____

Address: _____ City: _____

State: ____ Zip: _____ Home Phone: _____ Mobile: _____

Email: _____ SS#: _____

Birth Date: _____ ❑Single ❑Separated ❑Married ❑Divorced ❑Widowed

Employer: _____ Work Phone: _____

Occupation: _____ Family Doctor: _____

Referred By: ❑Friend ❑Relative ❑Newspaper Ad ❑Yellow Pages ❑Sign ❑Doctor ❑Other:_____

Which one of our patients may we thank for referring you? _____

Have you ever been to a chiropractor before? ❑Yes ❑No If yes, who did you see? _____

What kind of results did you have? _____

### In case of emergency, contact:

Name: _____ Relationship: _____

Home: _____ Mobile: _____ Work: _____

### Current Condition

What is the reason for your visit today? _____

Is your condition due to an accident? ❑Yes ❑No If yes, when did it happen? _____

Type of accident: ❑Auto ❑Work ❑Home ❑Other

To whom have you made a report of the accident? ❑Auto Insurance ❑Employer ❑Worker Comp ❑Other

Attorney Name (if applicable) _____

How will you be paying for your care? ❑Cash ❑Check ❑Credit Card ❑Insurance

### Patient Health Information Privacy

We want you to know that your Patient Health Information (PHI) will only be used for the purposes of treatment, payment and coordination of care. Be assured that this office will limit the release of all PHI to the minimum needed. You have the right to examine and obtain a copy of your PHI at any time and request corrections. All staff has been trained in the area of patient record privacy. We encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent. By signing, you understand and agree with how your records will be used.

X_____ **Date:** _____

**Signature of patient or person acting on patient's behalf**

Name: _____ Date: _____

## Health History

### Habits

| | | |
|---|---|---|
| Smoking | Packs/Day: | _____ |
| Alcohol | Cups/Day: | _____ |
| Coffee | Cups/Day: | _____ |
| Soft Drink | Cans/Day: | _____ |
| Sleep | Hours/Night: | _____ |

### Exercise

- ❑None
- ❑Moderate
- ❑Daily
- ❑Heavy

### Family History

| | Diabetes | Cancer | Back Pain | Other |
|---|---|---|---|---|
| Mother | ❑ | ❑ | ❑ | ❑_____ |
| Father | ❑ | ❑ | ❑ | ❑_____ |
| Grandparent | ❑ | ❑ | ❑ | ❑_____ |
| Sibling | ❑ | ❑ | ❑ | ❑_____ |

Height: _____ Weight: _____

**Please indicate if you have had any of the following:**

| | | | |
|---|---|---|---|
| ❑ AIDS/HIV | ❑ Constipation | ❑ High Blood Pressure | ❑ Pleurisy |
| ❑ Alcoholism | ❑ Diabetes | ❑ High Cholesterol | ❑ Pneumonia |
| ❑ Allergies | ❑ Diarrhea | ❑ Kidney Disorder | ❑ Polio |
| ❑ Anemia | ❑ Dizziness | ❑ Kidney Stones | ❑ Prostate Problem |
| ❑ Anorexia | ❑ Earache | ❑ Liver Disease | ❑ Psychiatric Care |
| ❑ Appendicitis | ❑ Eczema | ❑ Measles | ❑ Rheumatic Fever |
| ❑ Arthritis | ❑ Emphysema | ❑ Migraine Headaches | ❑ Rheumatoid Arthritis |
| ❑ Asthma | ❑ Epilepsy | ❑ Multiple Sclerosis | ❑ STD |
| ❑ Breast Lump | ❑ Fracture | ❑ Mumps | ❑ Stroke |
| ❑ Bulimia | ❑ Goiter | ❑ Nausea | ❑ Thyroid Problem |
| ❑ Cancer | ❑ Gout | ❑ Night Sweats | ❑ Tuberculosis |
| ❑ Chemical Dependance | ❑ Heart Disease | ❑ Osteoporosis | ❑ Tumors, Growths |
| ❑ Chest Pain | ❑ Hepatitis | ❑ Pacemaker | ❑ Ulcers |
| ❑ Chicken Pox | ❑ Hernia | ❑ Parkinson's | ❑ Whooping Cough |
| ❑ Chronic Cough | ❑ Herniated Disc | ❑ Pinched Nerve | ❑ Other: _____ |

In general, would you say your health is: ❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor

Are you currently taking any medications (prescription or over-the-counter)? ❑Yes ❑No

If yes, which ones?: _____

Are you taking any vitamins or supplements? ❑Yes ❑No

If yes, which ones?: _____

Have you ever had any surgeries or been hospitalized (does not include uncomplicated labor)? ❑Yes ❑No

If yes, please give the approximate date and reason: _____

_____

Are there any other issues the doctor should be aware of? _____

_____

**Females Only**: Are you pregnant at this time? ❑Yes ❑No Due Date: _____

Name: _____ Date: _____

**List the symptoms you are experiencing today from most severe (1) to least (3).**

1._____

Severity level: ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Type of pain: ❑Sharp ❑Dull ❑Achy ❑Numb ❑Throbbing ❑Shooting ❑Burning ❑Stiffness

How often do you feel this? ❑Constant ❑Daily ❑Off & On ❑Weekly ❑Monthly ❑Other _____

How did it begin (injury, gradually, etc.)? _____

How long have you had this problem? _____ Is it getting: ❑Better ❑Worse ❑Same

What makes it better? _____ What makes it worse? _____

Helping this issue would increase my quality of life by: ❑10-20% ❑30-40% ❑50-60% ❑70-80% ❑90% ❑100%

2._____

Severity level: ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Type of pain: ❑Sharp ❑Dull ❑Achy ❑Numb ❑Throbbing ❑Shooting ❑Burning ❑Stiffness

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3._____

Severity level: ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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## Consent for Treatment

I certify that the above information is correct. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. I understand that no cures are promised or implied and any risks regarding care at this office will be explained to me upon my request.

X_____ Date: _____

**Signature of patient or person acting on patient's behalf**

Name: _____ Date: _____

**Pain Diagram**

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.

A=Ache B=Burning N=Numbness S=Stabbing T=Tingling O=Other