New Patient Intake Form

Patient Information

First Name: ___________________________ M.I. _________ Last Name: _________________________________
Address: ____ City: _____________________________________
State: _____ Zip: __________ Home Phone: ____________________ Mobile: _____________________________
Email: ____________________________________ DOB: ___/___/_____ SS#: ______________________________

☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

Employer: ____ Work Phone: _________________________
Occupation: ____ Family Doctor: ________________________
Referred By: ☐ Friend ☐ Relative ☐ Ad ☐ Doctor ☐ Other: ___________________

Which one of our patients may we thank for referring you?_____________________________________
Have you 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
Whom have you reported the accident to? ☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other
Attorney Name: ______________________
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 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 that you agree with how your records will be used.

X____ **Date:** ______________

Signature of patient of person acting on patient's behalf

Name: ____ **Date:** ____________________

Health History

Habits:

Smoking Packs/Day: ______
Alcohol Cups/Day: ______
Coffee Cups/Day: ______
Soft Drinks 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
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Lump
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependance
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Chronic Cough
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Earache
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fracture
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hernia
- ☐ Hepatitis
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disorder
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nausea
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pinched Nerve
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Ulcers
- ☐ Whooping Cough
- ☐ Other: _____________

How would you rate your health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you currently taking any medications (prescription or over-the-counter)?
If yes, which ones?

____

Are you taking any vitamins or supplements? ☐ Yes ☐ No
If yes, which ones?

____

Have you had any surgeries/ been hospitalized (not including uncomplicated labor)? ☐ Yes ☐ No
If yes, please give approx. date and reason: ____
Are there any other issues the doctor should be aware of?

____

Females Only: Are you pregnant at this time? ☐ Yes ☐ No

If yes, Due date: ____

Name: ____ **Date:** ____________________

Please list your main area(s) of pain you are experiencing today:

1. ____

Severity level:

☐ (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ (7) ☐ (8) ☐ (9) ☐ (10)

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? _________________

2. ____

Severity level:

(1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ (7) ☐ (8) ☐ (9) ☐ (10)

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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