New Patient Intake Form

Date ____/____/_____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial ____ Last Name_____

Address: City _____State _____ Zip Code _____

Home Phone (_____) _____-_____ Cell (_____) _____-_____Email _____

Date of Birth ____/____/_____ **Age**_____ **Sex:** Male Female **Social Security #: _____-_____-_____**

Marital Status: Single Married Other

Spouse's name_____# of children_____

Employment Status: Employed Unemployed FT Student PT Student Retired Other_____

Employer_____ Occupation _____

Emergency Contact_____ Phone (_____) _____-_____

Primary Care Provider_____

Other Providers seen for current condition_____

How did you hear about our office? _____

Previous Chiropractic Care? _____ Name of Chiropractor_____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse
Auto Insurance Medicare Medicaid Other_____
Please provide a copy of your driver's license and Insurance card if applicable.

Health Insurance Carrier: _____ ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____

Auto / Personal Injury:
Is your visit due to injuries sustained in a motor vehicle accident or personal injury claim? ____
Date of Injury? _____
Attorney_____ Adjuster_____

Please describe the symptoms that brought you to our office.

_____

_____

_____

When did the symptoms begin? _____

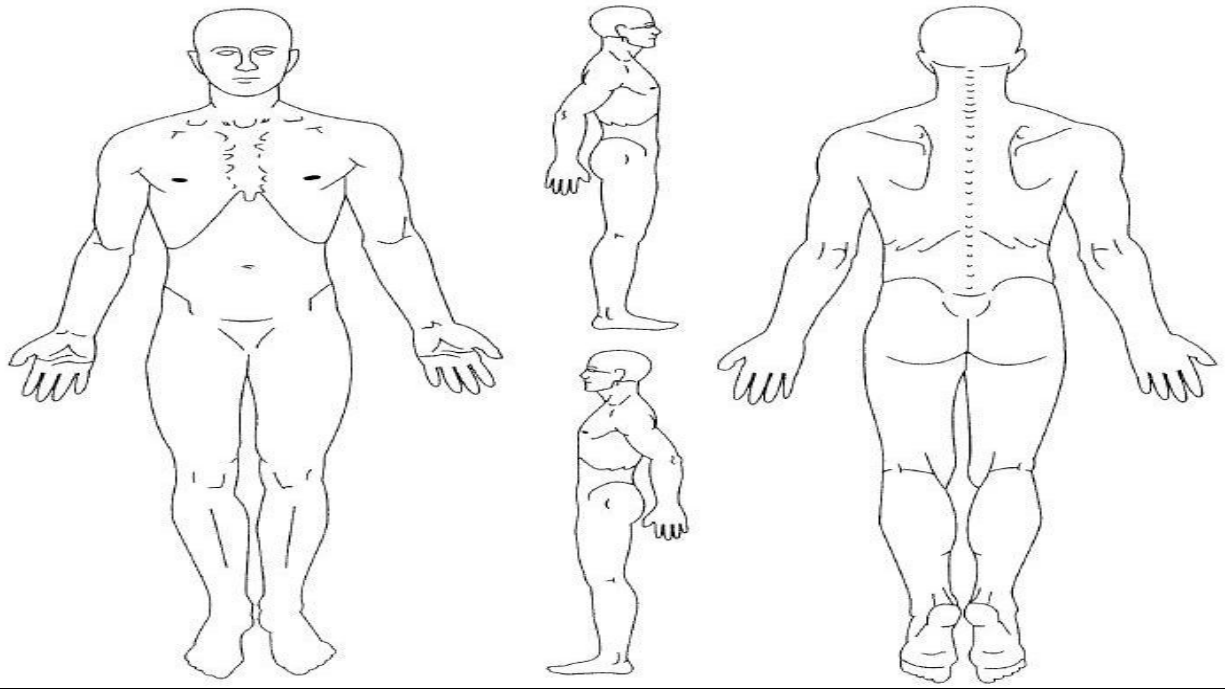
How did your symptoms begin? _____
Severity of pain? 0 1 2 3 4 5 6 7 8 9 10

Nature of Pain? Sharp Dull ache Numb Shooting Burning Tingling
Stabbing Other _____

How often do you have symptoms?
Constantly Frequently Occasionally intermittently

Previous treatment for this condition? _____

Indicate the area(s) of pain in the diagram below.



What makes the symptoms better?	What makes the symptoms worse?	What do the symptoms prevent you from doing, or limit your ability to do?

Medical Conditions: (Check all that apply to you)

Arthritis Cancer Diabetes Heart Disease Hypertension
Psychiatric Illness Skin Disorder Stroke
Rheumatoid Arthritis Ehlers-Danlos Syndrome Other (describe below)

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia

Other: (describe below)

Are you currently pregnant, or is there a possibility that you are pregnant? **Do you have a pacemaker or Defibrillator?** **Do you have any surgical implants, devices?**	**Please list all current Prescription & OTC Medications:**

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Social History: (Check all that apply to you)

Caffeine use: occasional often never Alcohol: occasional often never
Exercise: occasional often never
Tobacco: occasional often never

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____
Patient's Signature _____
Consent to Treat a Minor: (Minor's Printed Name) _____
Guardian / Spouse's Signature Authorizing Care _____