Chiropractic New Patient Intake Form

Date _____

PATIENT DATA

Title: (Check One) ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

Date of Birth _____ Sex: ❑ Male ❑ Female

Social Security Number _____ Marital Status ❑ Single ❑ Married ❑ Other

Employment Status ❑ Employed ❑ Unemployed ❑ FT Student ❑ PT Student ❑ Other

SPOUSE DATA

First Name _____ Middle Initial _____ Last Name _____

Home Phone (_____) _____ Work Phone (_____) _____

EMPLOYER DATA

Name _____

Your Occupation _____ Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

EMERGENCY CONTACT

Contact Name _____

Contact Home Phone (_____) _____ Cell Phone (_____) _____

Who referred you to our office? _____

❑ Website ❑ Insurance ❑ Sign ❑ Yellow Pages ❑ Other _____

Patient Name _____ **Date** _____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke

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

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

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

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper

Patient Name _____ **Date** _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

_____

_____

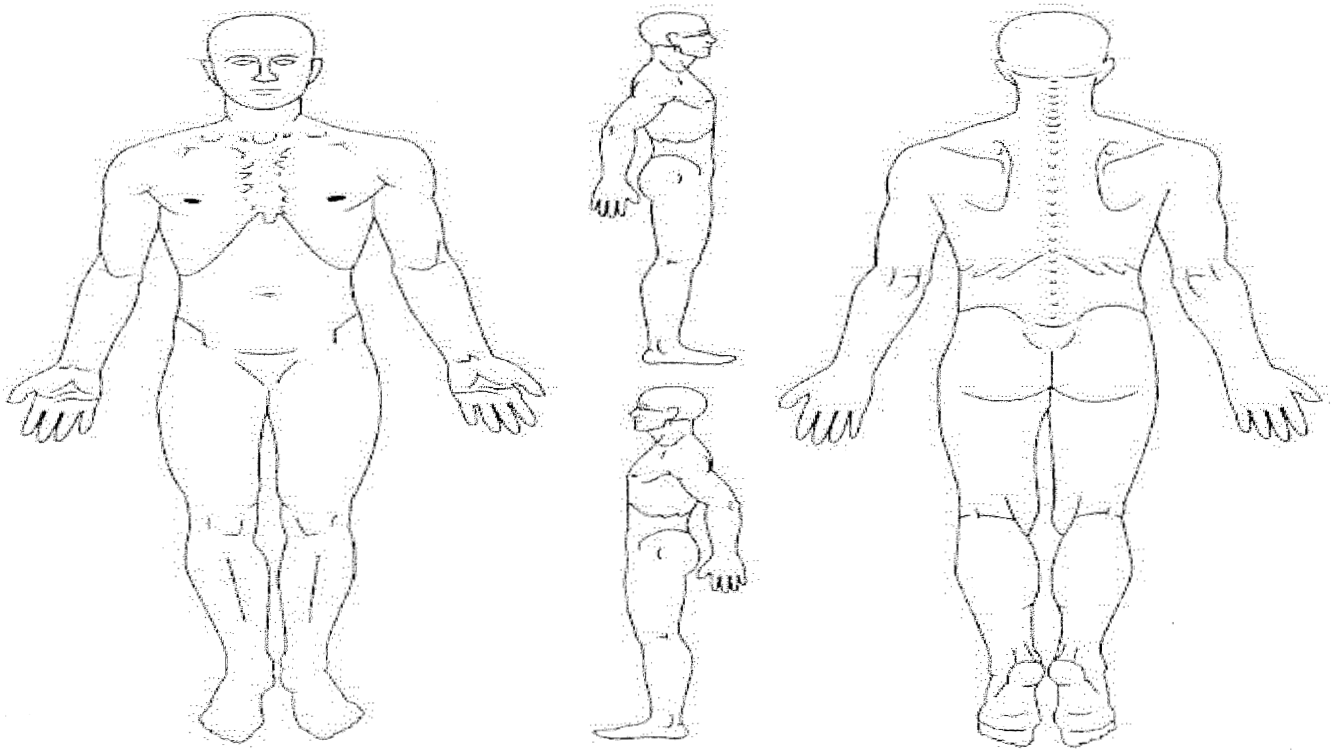
_____

Pregnant? ❑ Yes ❑ No

Patient Name _____ **Date** _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

When did your symptoms begin? **Month**_____ **Day**_____**Year** _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp
☐ Dull ache
☐ Numb
☐ shooting
☐ Burning
☐ Tingling
☐ Stabbing

How are your symptoms changing?

☐ Getting better
☐ Not changing
☐ Getting worse

Patient Name **Date**

INSURANCE INFORMATION:

Who is responsible for your bill? ❑ You...Mark Appropriate box(es) ❑ Myself Only

❑ Spouse ❑ Worker's Comp ❑ Auto Insur. ❑ Medicare ❑ Medicaid ❑ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID# _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth: _____ / _____ / _____ Primary Care Physician: _____

Policy Holder's Employer: _____

Please give your license and insurance card to the receptionist for copy and verification. Thank you.

NOTICE:

How will you be paying for today's charges? ❑ Visa ❑ Mastercard ❑ Debit ❑ Check ❑ Cash

I authorize Chiropractic Partners to release any and all information to my insurance company, my attorney, or my insurance adjuster. I realize that I am ultimately responsible for all charges incurred in the event that my insurance does not pay. I authorize medical payments directly to Chiropractic Partners for any services or supplies.

Patient Signature: _____ Legal Guardian: _____

Attending Doctor's Signature: _____ Date: _____