NEW PATIENT INTAKE FORM

Personal Information

Name: _____Date: _____

Address: _____

City: _____State: _____ Zip: _____

WHOM MAY WE THANK FOR REFERRING YOU?

Home Phone: (_____) _____Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Leave messages on: *Home* *Work* *Cell* *Don't leave messages*

WOULD YOU LIKE TO RECEIVE A PATIENT NEWSLETTER VIA EMAIL? *Yes* *No*

Date of Birth (Month/Day/Year): _____ Gender: *Male* *Female*

SSN: _____-_____-_____ Marital Status: *Single* *Married* *Other:* _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____ **PHONE NUMBER:** (_____) _____

Primary Care Physician: _____

City: _____ State: _____ Phone Number: (_____) _____

Insurance Information

Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____

Date of Birth of Insured: _____ Relationship to Patient: _____

Employment Status: *Full-time* *Part-time* *Seasonal* *Self-employed* *Unemployed* *Retired*

Employer: _____Occupation: _____

If retired, what was your life's work? _____

Primary Health Concern

The primary symptom that prompted you to seek care today is: _____

_____

Is this a result of an accident or injury? *Yes* *No*
If so, was it related to? *Auto* *Work*

Onset (when did you first notice these symptoms?) _____

The pain can be best described as: *Achy* *Dull* *Sharp* *Burning* *Numb* *Stabbing*

Other (explain): _____

What makes this better? _____

worse? _____

Explain how this condition interferes with:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

Secondary Health Concern

The secondary symptom that prompted you to seek care today is: _____

_____

Is this a result of an accident or injury? *Yes* *No*
If so, was it related to? *Auto* *Work*

Onset (when did you first notice these symptoms?) _____

The pain can be best described as: *Achy* *Dull* *Sharp* *Burning* *Numb* *Stabbing*

Other (explain): _____

What makes this better? _____

worse? _____

Explain how this condition interferes with:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

Review of Systems

Please mark with an X any condition that you HAD or currently HAVE.

1. Musculoskeletal

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Osteoporosis	____	____	Arthritis	____	____	Scoliosis
____	____	Neck pain	____	____	Back problems	____	____	Hip disorders
____	____	Knee injuries	____	____	Foot/ankle pain	____	____	Elbow/wrist pain
____	____	TMJ issues	____	____	Poor Posture	____	____	Shoulder issues

2. Neurological

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Anxiety	____	____	Depression	____	____	Headache
____	____	Dizziness	____	____	Pins/needles	____	____	Numbness

3. Cardiovascular

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	High BP	____	____	Low BP	____	____	High cholesterol
____	____	Poor circulation	____	____	Angina	____	____	Excess bruising

4. Respiratory

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Asthma	____	____	Sleep Apnea	____	____	Emphysema
____	____	Hay fever	____	____	Shortness of breath	____	____	Pneumonia

5. Digestive

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Ulcer	____	____	Heartburn	____	____	Anorexia/bulimia
____	____	Constipation	____	____	Diarrhea	____	____	Food sensitivities

6. Sensory

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Blurred vision	____	____	Ringing in ears	____	____	Hearing loss
____	____	Ear infections	____	____	Loss of smell	____	____	Loss of taste

7. Skin

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Skin cancer	____	____	Psoriasis	____	____	Eczema
____	____	Acne	____	____	Hair loss	____	____	Rash

8. Endocrine

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Thyroid issues	____	____	Immune disorders	____	____	Hypoglycemia
____	____	Freq. infection	____	____	Swollen glands	____	____	Low energy

9. Genitourinary/Constitutional

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Kidney stones	____	____	Infertility	____	____	Bed wetting
____	____	Prostate issues	____	____	Erectile dysfunction	____	____	PMS symptom
____	____	Fainting	____	____	Low libido	____	____	Poor appetite
____	____	Fatigue	____	____	Weakness	____	____	Sudden weight gain/loss

Past Personal, Family, And Social History

Have you ever seen a chiropractor before? *Yes* *No*

If so, name of doctor and date of last visit: _____

Women: Are you pregnant? *Yes* *No* If so, what is your due date? _____

Date of last period: _____ How many pregnancies? _____

Personal Illnesses: Please mark an X by those you have HAD or HAVE now.

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	AIDS	____	____	Alcoholism	____	____	Allergies
____	____	Arteriosclerosis	____	____	Cancer	____	____	Chicken Pox
____	____	Diabetes	____	____	Epilepsy	____	____	Glaucoma
____	____	Goiter	____	____	Gout	____	____	Heart disease
____	____	Hepatitis	____	____	HIV Positive	____	____	Malaria
____	____	Measles	____	____	MS	____	____	Mumps
____	____	Polio	____	____	Rheumatic fever	____	____	Scarlet fever
____	____	STD	____	____	Stroke	____	____	TB
____	____	Typhoid fever	____	____	Ulcer	____	____	Other: _____

Operations: Please list any surgical intervention that may or may not have included hospitalization. _____

_____

_____

Treatments: Please mark and X by those you HAD or are CURRENTLY receiving.

HAD	CURRENTLY		HAD	CURRENTLY	
____	____	Acupuncture	____	____	Antibiotics
____	____	Birth control pills	____	____	Blood transfusions
____	____	Chemotherapy	____	____	Chiropractic care
____	____	Dialysis	____	____	Herbal therapy
____	____	Homeopathy	____	____	Hormone replacement
____	____	Inhaler	____	____	Massage therapy
____	____	Physical therapy	____	____	Medications

Medications: Please list all prescriptions, over-the-counter remedies, natural supplements and/or vitamins you currently take: _____

_____

_____

Injuries: Have you ever:

____ Broken a bone
____ Had a spine or nerve disorder
____ Been knocked unconscious
____ Been injured in an accident
____ Had to use crutches or other supports
____ Used neck or back bracing
____ Had a concussion diagnosed (if so, how many _____)

Family History:

Some health issues have a heredity component. Please tell us about the health of your immediate family members.

Relative	*Age (if alive)*	*State of health*	*Illnesses*	*Age of death*
Mother	_____	Good / Poor	_____	_____
Father	_____	Good / Poor	_____	_____
Sibling	_____	Good / Poor	_____	_____
Sibling	_____	Good / Poor	_____	_____
Sibling	_____	Good / Poor	_____	_____
Sibling	_____	Good / Poor	_____	_____

Are you aware of any other heredity issues? _____

_____

Are you interested in learning more about the benefits of having your whole family under chiropractic care? *Yes* *No* *Explain:* _____

Social History / Health Habits / Stress Levels:

Tobacco use: *Never a smoker* *Former smoker* *Daily smoker*
Exposed to second-hand smoke *Occasional smoker* *Heavy smoker* *Light smoker*

Place an X on what best describes you.

	Daily	*Weekly*	*How much?*		*Yes*	*No*
Alcohol use	_____	_____	_____	Prayer /meditation	____	____
Coffee use	_____	_____	_____	Job pressure/stress	____	____
Exercise	_____	_____	_____	Financial peace	____	____
Pain relievers	_____	_____	_____	Vaccinated	____	____
Soft drinks	_____	_____	_____	Mercury fillings	____	____
Water intake	_____	_____	_____	Recreational drugs	____	____

Activities of Daily Living:

Currently, how have these activities interfered with your life and ability to function?

	None	*Mild*	*Moderate*	*Severe*
Sitting	____	____	____	____
Getting up from a chair	____	____	____	____
Standing	____	____	____	____
Walking	____	____	____	____
Lying down	____	____	____	____
Bending over	____	____	____	____
Climbing stairs	____	____	____	____
Using the computer	____	____	____	____

	None	*Mild*	*Moderate*	*Severe*
Getting in/out of the car	____	____	____	____
Driving a car	____	____	____	____
Looking over shoulder	____	____	____	____
Caring for family	____	____	____	____
Grocery shopping	____	____	____	____
Household chores	____	____	____	____
Lifting objects	____	____	____	____
Reaching overhead	____	____	____	____
Showering or bathing	____	____	____	____
Dressing myself	____	____	____	____
Love life	____	____	____	____
Getting to sleep	____	____	____	____
Staying asleep	____	____	____	____
Concentrating	____	____	____	____
Exercising	____	____	____	____
Yardwork	____	____	____	____

What is the major stressor in your life? _____
_____
_____

How many hours of sleep do you average per night? _____ How many times do you wake up during the night? _____ Do you nap during the day? *Yes* *No*

Are there any other health goals that you'd like to discuss now? *Yes* *No*

If so, please describe: _____
_____
_____

Is there anything else I need to know to better assist you? *Yes* *No*

If so, please explain: _____
_____
_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will respect the privacy of your health information. We may have to use or disclose your healthcare or billing information when:

1. It is necessary to refer you to another healthcare provider or hospital for the diagnosis, assessment, or treatment of your health condition.
2. Another party, such as a health insurance company, is responsible for payment of your services.
3. We need the information within our practice for quality control or other operational purposes.

Along with this consent form you will be given, at your request, a copy of our privacy notice that describes our privacy policy in detail. You have the right to review the notice before you sign this consent form. We reserve the right to change our privacy practices as described in this notice. If we make changes, we will notify you in writing.

Your chiropractor and members of the staff may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages as described above.

We do not give or sell patient information to any outside marketing organizations. All marketing services are by those staff members in our practice.

YOU HAVE THE RIGHT TO LIMIT USES OF DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. Although we are not required to agree to your restrictions, if we choose to do so, the restrictions are binding on us.

YOU HAVE THE RIGHT TO REVOKE AUTHORIZATION

You may revoke any authorization at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released health information prior to receiving your request. If you are required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if we decide to contest any of your claims.

I have read the consent policy and agree to its terms. I also acknowledge that I have been offered and/or received a copy of this consent form and a copy of the privacy notice (Notice of Privacy Practices for Protected Health Information).

_____	_____
PRINT NAME OF PATIENT/LEGAL REPRESENTATIVE	**DATE**
_____	_____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE	**RELATIONSHIP TO PATIENT**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT OF CARE

PATIENT NAME: _____

I, hereby, request and consent to the performance of procedures which are within the scope of practice of chiropractic, including but not limited to, chiropractic adjustments, various modes of physical therapy, and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by Dr. Heather Sweet and/or any other licensed doctor or chiropractor who will now or in the future treat me while being employed by, working or associated with, or serving as back-up for Dr. Heather Sweet at Sweet Family Chiropractic.

I have had the opportunity to discuss with Dr. Heather Sweet and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that there are some risks to chiropractic treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains/strains. I do not expect the doctor to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgement during the procedure which the doctor deems is in my best interest at the time and is based on the facts known.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

PRINT NAME OF PATIENT/LEGAL REPRESENTATIVE **DATE**

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**