

Patient Intake Form

Date: _____

Name: _____ Social Security # _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Fax: _____ Cell Phone: _____

Best way to contact you: Home Work Cell

Age: _____ Birth Date: _____ Marital: M S W D

Occupation: _____ Employer: _____

Work Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

Names and Ages of Children: _____

Name of Emergency Contact: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. [The following person\(s\) have my permission to receive my personal health information:](#)

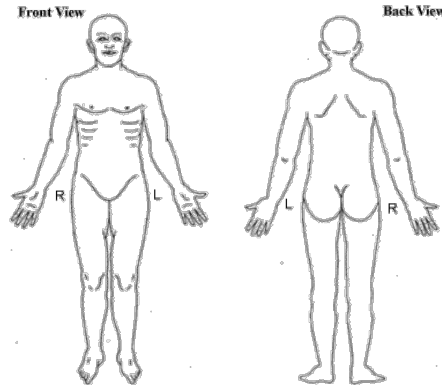
Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Name: _____ Date: _____

1. Is today's problem caused by Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pains/ symptoms



Complaint #1: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp Numb
- Dull Tingly
- Diffuse Sharp with motion
- Achy Shooting with motion
- Burning Stabbing with motion
- Shooting Electric- like with motion
- Stiff
- Other: _____

How are your symptoms changing with time?

- Getting Worse Staying the Same
- Getting Better

Using a scale from 0-10 (10 being the worst)

How would you rate your problem?

(Please Circle)

0 1 2 3 4 5 6 7 8 9 10

How much has the problem interfered with your work?

- Not at all A little bit Moderately
- Quite a bit Extremely

Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
- ER Physician Orthopedist Other: _____
- Massage Therapist Physical Therapist
- No one

How long have you had this problem? _____

How do you think this problem began? _____

Do you consider this problem to be severe?

- Yes Yes, at times No

What aggravates your problem?

What concerns you the most about your problem; what does it prevent you from doing?

Complaint #2: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp Numb
- Dull Tingly
- Diffuse Sharp with motion
- Achy Shooting with motion
- Burning Stabbing with motion
- Shooting Electric- like with motion
- Stiff
- Other: _____

How are your symptoms changing with time?

- Getting Worse Staying the Same
- Getting Better

Using a scale from 0-10 (10 being the worst)

How would you rate your problem?

(Please Circle)

0 1 2 3 4 5 6 7 8 9 10

How much has the problem interfered with your work?

- Not at all A little bit Moderately
- Quite a bit Extremely

Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
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- Massage Therapist Physical Therapist
- No one

How long have you had this problem? _____

How do you think this problem began? _____

Do you consider this problem to be severe?

- Yes Yes, at times No

What aggravates your problem?

What concerns you the most about your problem; what does it prevent you from doing?

What is your: Height _____ Weight _____ DOB _____

Occupation _____

How would you rate your overall health?

- Excellent Very Good Fair Poor

What type of exercises do you do?

- Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Loss/Gain	FOR FEMALES ONLY	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

Social History

Drugs: _____ Coffee: _____ Cups/Day
Work: _____ Hours/Day Sleep: _____ Hours/Night
Exercise: _____ /Week Vitamins: _____

List all prescription medications you are currently taking:

List all of the over-the-counter medications/supplements you are currently taking:

List all surgical procedures you have had:

What activities do you do at work?

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

What activities do you do outside of work?

How are your current problems affecting these activities or hobbies? _____

Have you ever been hospitalized? No Yes

If yes, why? _____

Have you had significant past trauma? No Yes

Anything else pertinent to your visit today?

On a scale of 0-10 (0 being the least and 10 being the most)

_____ **How committed are you to being at your maximum health potential?**

_____ **How important is it for your family to be at their optimum health potential?**

If you have previously seen a chiropractor, please describe your likes or dislikes (if any) so we may better serve you.

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient _____

Date _____