Patient Intake Form

Date: __________________

Name: ____________________________ Social Security #__________________Home Phone: _______________

Address: ____________________________________City:___________________ State: ______ Zip: ___________

E-mail address: __________________________ Fax: __________________ Cell Phone: __________________

Best way to contact you: O Home O Work O 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**:**

O Major Medical O Worker's Compensation O Medicaid O Medicare O Auto Accident

O 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:

____

____

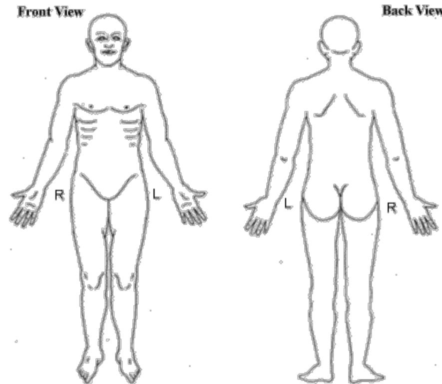
Patient's Signature: ____ Date: ________________

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

6. 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?

____

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

☐ Sit: ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ Stand: ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ Computer work ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ On the phone ☐ Most of the day ☐ Half the day ☐ 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 ____________________________________