New Patient Intake Form

1. Please enter your information.

First Name: | Middle Initials: | Last Name: | Date of Birth:

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone:

Email:

Preferred contact method:
○ Mobile Phone ○ Text ○ Email ○ Home Phone ○ Work Phone

DL# | SSN:

How were you referred to our office? | Height: | Weight:

Occupation: | Employed By:

What is the name of your physician? | In what city are they located?

Have you ever had Chiropractic care before?
○ Yes ○ No

If yes, doctor's name:

Health Insurance Co Name: | Policy Holder:

Policy Holder's Date of Birth: | Insurance ID Number:

2. If you are experiencing any pain (neck, low back pain, mid back pain, etc.) or health problems, please list them here:

Condition: | For how long?

Condition: | For how long?

Condition: | For how long?

Condition: | For how long?

Has the problem been getting worse or staying the same?

○ Staying the same ○ Getting worse

Currently or in the past have you ever experienced any of these complaints while working?

○ Yes ○ No

What activities at work may be causing you to experience these complaints?

Are there any other activities, incidents, or events outside of work that may have caused these complaints?

○ Yes ○ No

If yes, what are they?

Have you ever had any surgeries or hospitalizations?

○ Yes ○ No

If yes, please list here:

List ALL medications you are currently taking (prescribed and over-the-counter) including vitamins, birth control, pain remedies, etc.

3. **We would like to know how much your condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. For each of the following categories, please choose a number that indicates how much your condition is interfering with your activities of daily living with 0 being NOT AT ALL and 10 being the worst.**

Family/Home Responsibilities: activities related to the home or family (yard work, doing dishes, errands, helping family members, driving children to school, laundry, cleaning, etc)

Recreation: hobbies, sports, physical fitness, and any leisure time activities.

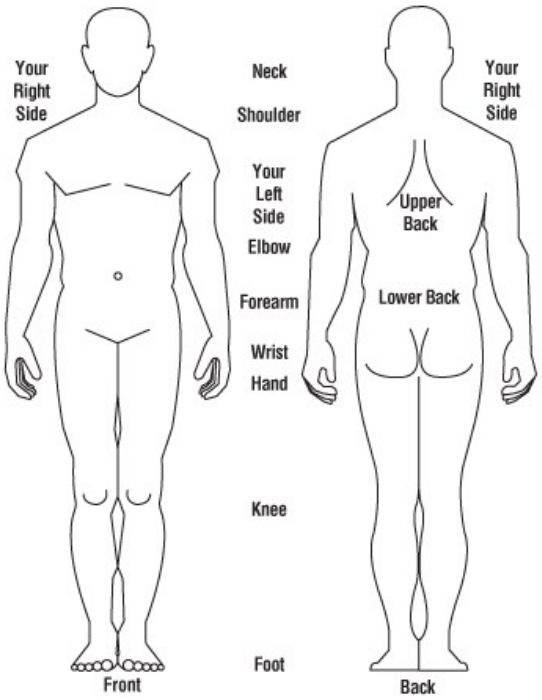
Social Activity: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.

Occupation: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker.

Self Care: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)

Life Support Activity: basic life supporting behaviors such as sleeping, eating, and breathing.

4.Please indicate areas of concern:



5. **Chiropractors are specialists in treating conditions related to the spine, but they are also trained in overall health care. Most of our patients are concerned with their overall health, but occasionally we do have patients who do not want extensive health care. We want to give you the type of care that you are looking for. Please read the following and choose the statement that most closely applies to your expectations.**

- ○ I am interested in more extensive health care. I understand that this means a more detailed examination today, and might require additional testing procedures over the course of my treatment (possible testing procedures might include one or more of the following: x-rays, MRI, blood work, urinalysis, salivary tests, etc.). I understand that I have the right to make informed decisions about my health, and I want as much information as possible about my condition and my overall wellness.
- ○ I am not interested in extensive health care. I only want an adjustment. I understand that this means problems may return in the future. I understand that there may be health concerns that are not identified. I understand that the doctor will still need to do an examination today to evaluate my condition, but it will not be as thorough as it could be. I understand that the doctor will discuss any concerns with me, and that I have the right to choose what I do with that information. I understand that most insurance policies will not cover an adjustment performed on the same day as the examination, and that the doctor will discuss my policy's specific coverage with me before we do any procedures that incur a charge.
- ○ I am not sure what would be best for me at this time. I want more information from the doctor before I make a decision.

6. **Method of Payment for today's charges:**

- ○ CASH
- ○ CHECK
- ○ CREDIT/DEBIT CARD

_____ _____

Signature Date