Chiropractic Connection

New Patient Intake Form

Name:_____ Today's Date:_____
First MI Last

Address:_____ Date of Birth: _____

City:_____ State: _____ Zip code:_____

Social Security Number:_____ Age: _____ Gender: Male □ Female □

Marital status: (circle one) Single, Married, Widowed, Divorced, Legally Separated

Spouses Name if married: _____ Primary Language if not English:_____

Ethnicity: (circle one) American Indian, Alaskan Native, Asian, African American, Hispanic/Latino, Native Hawaii/Pacific Islander, White

Contact Information:

Phone: Home: _____ Cell: _____ Work: _____

Email Address: _____ What is your contact preference? _____

Emergency Contact:_____
Name Phone #

_____
Address

Primary Care Physician: _____
Name Location Phone#

How did you hear about Chiropractic Connection? (circle one) Window Sign, Newspaper, Yellow Pages, Website, Word of Mouth, Know the Doctor, Referred by Patient _____
Patient's Name

Employer/School of the patient:

Name of company or school: _____ Job title: _____

Address: _____
City State zip code

Contact Personnel: _____ Phone: _____ Years Emp. _____

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Name of Responsible Party / (one carrying the insurance) _____

Company worked for: _____ Phone: _____

Address: _____
City State Zip Code

Contact Personnel:_____ Insurance Company: _____

Date of Birth: _____ Gender: _____ Social Security #: _____

Employee Insurance ID# _____ Group # _____

Group Name: _____ **(If cards are present at this visit we can copy the cards)**

What is patient being seen for today? _____

Has the patient ever had this same or a similar condition? Y / N When: _____

Is the patient currently under care with another physician for this condition? Y / N If yes, by whom: _____

Has the patient visited a chiropractor before today? Y / N If yes, by whom: _____

Is today's visit the result of an accident? Y / N

If yes to accident, what type: (circle) Auto, Work, School/Sport, Other _____

If Injury due to an Auto accident:
Insurance Company Name: _____ Policy #: _____

Address: _____ Claim# :_____
City State Zip code

Phone #: _____ Driver's License # _____

Patient History:

List any medical conditions that your are currently being treated for and the year treatment began:

_____

_____

_____

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Please indicate whether you or a family member listed below have had any of the following:

					Maternal		Paternal	
	Self	Mother	Father	Siblings	Grand Mother	Grand Father	Grand Mother	Grand Father
Cancer (specify type)								
Diabetes								
Stroke								
Heart Disease								
Vascular Disease								
High Blood Pressure								
High Cholesterol								
Liver Disease								
Kidney Disease								
Lung Disease								
Autoimmune Disease								

List any family member that are deceased and the cause of death: _____

_____

List all medications in use by the patient (including OTC, vitamins, etc.): **(patient lists can be copied at the front desk)**

_____

_____

_____

_____

_____

List any Allergies and what reaction that they cause (medication, food, environmental): _____

_____

_____

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HEATH HISTORY
CONFIDENTIAL

NAME (Last, First, MI): Date:

PLEASE CHECK ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE LAST YEAR

GENERAL
- ☐ cold hands/feet
- ☐ low energy
- ☐ dizziness
- ☐ allergies
- ☐ fatigue
- ☐ hot flashes
- ☐ insomnia
- ☐ spontaneous sweating
- ☐ night sweating
- ☐ lack of sweating
- ☐ recent weight loss
- ☐ recent weight gain
- ☐ aversion to heat
- ☐ aversion to cold
- ☐ weak immune system

NECK AND HEAD
- ☐ blurred vision
- ☐ floaters
- ☐ heaviness in the head
- ☐ headache
- ☐ phlegm in throat
- ☐ cataracts
- ☐ double vision
- ☐ earache
- ☐ ear discharge
- ☐ eye pain/strain
- ☐ corrected vision
- ☐ nasal obstruction
- ☐ nasal discharge
- ☐ loss of sense of smell
- ☐ hearing loss
- ☐ hoarseness
- ☐ nosebleeds
- ☐ recurrent sore throat
- ☐ red/inflamed eyes
- ☐ ringing in ears
- ☐ sinus problems

RESPIRATORY
- ☐ asthma
- ☐ persistent cough
- ☐ coughing blood
- ☐ shortness of breath
- ☐ recurrent bronchitis
- ☐ phlegm production
- ☐ difficulty inhaling
- ☐ difficulty exhaling

CARDIOVASCULAR
- ☐ chest pain
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ irregular heart beat
- ☐ poor circulation
- ☐ swelling of ankles
- ☐ varicose veins
- ☐ rib/side pain

GASTROINTESTINAL
- ☐ abdominal pain
- ☐ bloating
- ☐ belching
- ☐ gas
- ☐ constipation
- ☐ diarrhea/loose stools
- ☐ bloody stools
- ☐ black stools
- ☐ difficulty swallowing
- ☐ poor appetite
- ☐ heartburn/acid reflux
- ☐ hemorrhoids
- ☐ indigestion
- ☐ stomach ache
- ☐ nausea
- ☐ vomiting
- ☐ food sensitivities

DIET/LIFESTYLE
- ☐ vegetarian
- ☐ healthy diet
- ☐ eat fried foods
- ☐ eat much meat
- ☐ smoke
- ☐ drink alcohol
- ☐ drink coffee
- ☐ eat a lot of sweets
- ☐ exercise regularly
- ☐ exercise excessively
- ☐ lack of exercise

GENITOURINARY
- ☐ up at night to urinate
- ☐ dark urine
- ☐ blood in urine
- ☐ cloudy urine
- ☐ burning urination
- ☐ scanty urine
- ☐ profuse urine
- ☐ frequent urination
- ☐ poor bladder control
- ☐ urgency to urinate
- ☐ prolapsed bladder

MUSCULOSKELETAL

pain, weakness, numbness in:
- ☐ arms
- ☐ legs
- ☐ hands
- ☐ feet
- ☐ joints
- ☐ shoulders
- ☐ hips
- ☐ neck
- ☐ elbows
- ☐ knees

SKIN
- ☐ broken blood vessels
- ☐ blood not clotting
- ☐ bruise easily
- ☐ discoloration
- ☐ darkness around eyes
- ☐ bags under eyes
- ☐ swollen lymph nodes
- ☐ dry skin
- ☐ acne
- ☐ brittle nails
- ☐ premature gray hair
- ☐ dry, brittle hair
- ☐ hair loss

NEUROLOGICAL
- ☐ fainting
- ☐ convulsions
- ☐ handwriting change
- ☐ paralysis
- ☐ stroke
- ☐ seizures
- ☐ tremor
- ☐ clumsiness
- ☐ drowsiness
- ☐ vertigo

EMOTIONAL
- ☐ nervousness
- ☐ irritability
- ☐ anger
- ☐ troubling dreams
- ☐ weepy
- ☐ depression
- ☐ forgetfulness
- ☐ mind not clear
- ☐ anxiety
- ☐ fear
- ☐ unrestrained joy

MEN ONLY
- ☐ genital pain
- ☐ impotence
- ☐ genital sores
- ☐ lump in testicles
- ☐ discharge from penis
- ☐ nocturnal emission
- ☐ low sexual energy

WOMEN ONLY
- ☐ abnormal pap smear
- ☐ bleeding between periods
- ☐ irregular periods
- ☐ heavy periods
- ☐ painful periods
- ☐ premenstrual tension
- ☐ breast lumps
- ☐ low sexual energy
- ☐ vaginal discharges
- ☐ menopausal
- ☐ uterine prolapse
- ☐ facial hair
- ☐ may be pregnant
- ☐ pain with intercourse

Name:_____ Today's Date:_____

What are we seeing you for today?

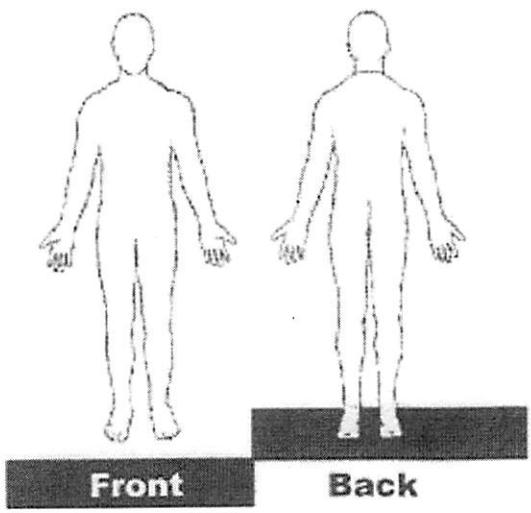
1._____
Rate your pain for this complaint: 0 1 2 3 4 5 6 7 8 9 10 Dull Achy Sharp Stabbing Numb Tingles Stiff
How often does pain occur? Occasional Intermittent Frequent Constant Since When?_____
If this is an ongoing condition is this complaint getting worse, staying the same, or improving?
Tell what makes this condition better and what makes it worse (sitting, standing, cold, heat etc)?_____

2._____
Rate your pain for this complaint: 0 1 2 3 4 5 6 7 8 9 10 Dull Achy Sharp Stabbing Numb Tingles Stiff
How often does pain occur? Occasional Intermittent Frequent Constant Since When?_____
If this is an ongoing condition is this complaint getting worse, staying the same, or improving?
Tell what makes this condition better and what makes it worse (sitting, standing, cold, heat etc)?_____

3._____
Rate your pain for this complaint: 0 1 2 3 4 5 6 7 8 9 10 Dull Achy Sharp Stabbing Numb Tingles Stiff
How often does pain occur? Occasional Intermittent Frequent Constant Since When?_____
If this is an ongoing condition is this complaint getting worse, staying the same, or improving?
Tell what makes this condition better and what makes it worse (sitting, standing, cold, heat etc)?_____

Pain Guide: 0 - none, 1 - I don't notice it until asked about it, 2- mild and notice it occasionally, 3- mild and persistent 4-moderate but not taking any OTC meds for it, 5-need OTC medication, 6- OTC meds no longer able to alleviate pain, 7-taking prescription pain medication, 8-prescription pain meds no longer able to alleviate pain, 9-need ER care, 10-contemplating suicide.

Show Areas of pain or symptoms on the picture below.



Mark Areas as follows:

A - Achiness

D-Decreased or No Motion

S - Sharpness

T - Stabbing

M-Spasms

N- Numbness or Tingling

W-Swelling

O - Other

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List any bones that been fractured and when: _____

_____

List past surgeries and dates: _____

_____

_____

List any hospitalizations not covered by surgeries and the dates: _____

_____

_____

Smoking Status (Circle): Current every day, Current some days, Former _____, Never Smoked
Quit Date

Do you live with a smoker in your home? Y / N

Alcohol Status (Circle): None, Drink Beer, Drink Wine, Casual Drinker, Moderate Drinker, Heavy Drinker
(Hard Liquor Answers)

Drug Use Status: (Circle): None, Recreational User, Addiction Type Drug Used: _____

Exercise (Circle): None, Daily, Weekly, Walks, Runs, Swims Type and Duration: _____

List any previous occupations and dates that put you in contact with smoke, fumes, toxins, chemicals, biohazards, etc...

_____

_____

_____

In a single day how many servings do you consume of: Water ____ Caffeinated beverages _____ Vegetables ____

Fruits ____ Meat _____ Dairy _____ Grain/Sugar Carbohydrates _____ Junk Food _____

How many hours do you sleep do you get each night? _____ Do you have trouble sleeping? Y / N

Is trouble sleeping due to pain? Y / N

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- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. This office is happy to file electronically to any insurance company that you may have for reimbursement to the patient for any chiropractic benefits they may have. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during the diagnosis and treatment. I also authorize the provider and/or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

Adult patient □ Parent or Guardian □ Spouse □