Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

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

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

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

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize [clinic name] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to [clinic name] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

_____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

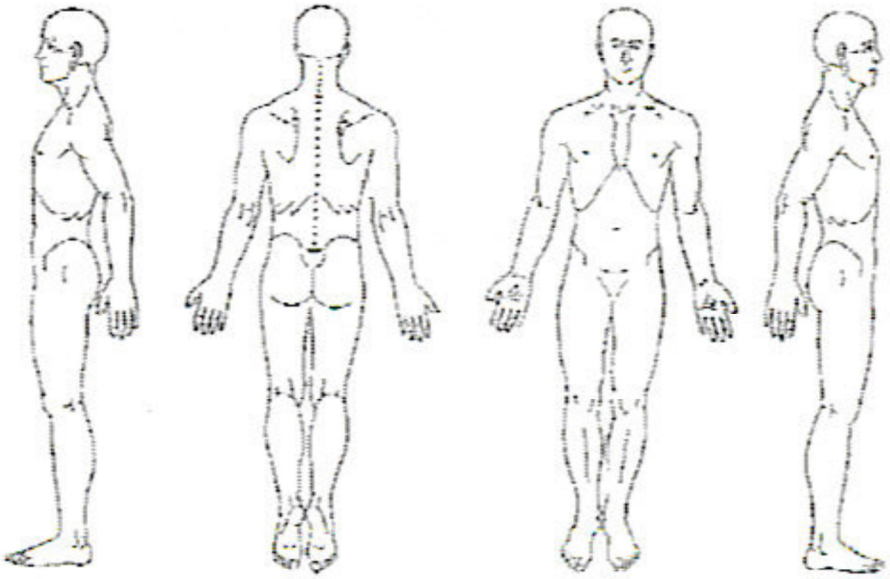
_____

_____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____