

Chiropractic New Patient Intake Form

Patient Data

Date _____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial _____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____ Sex: Male Female

Social Security Number: ____ - ____ - ____ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other _____

Spouse Data

First Name _____ Middle Initial _____ Last Name _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Employer Data

Name _____

Your Occupation _____ Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Doctor's Signature _____

Patient Name _____

Date _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth ____ / ____ / ____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____ / ____ / ____ Time: ____ am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date _____

SIGNATURE OF PHYSICIAN: _____ **Date:** _____

Patient Name _____

Date _____

Are you pregnant? Yes _____ No _____ N/A _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

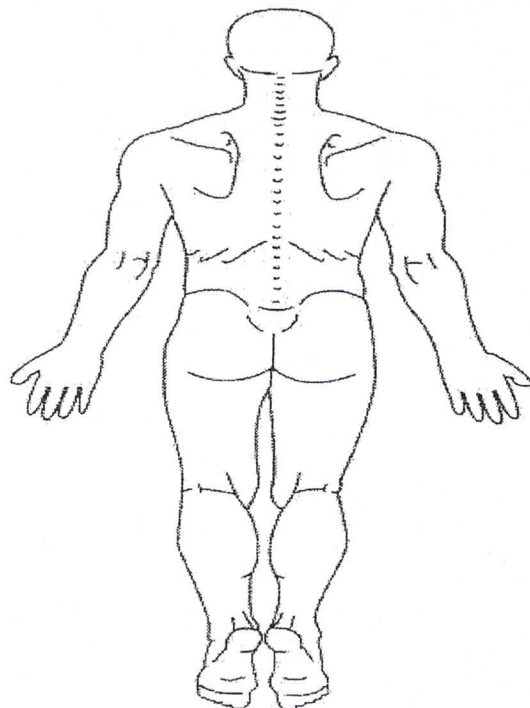
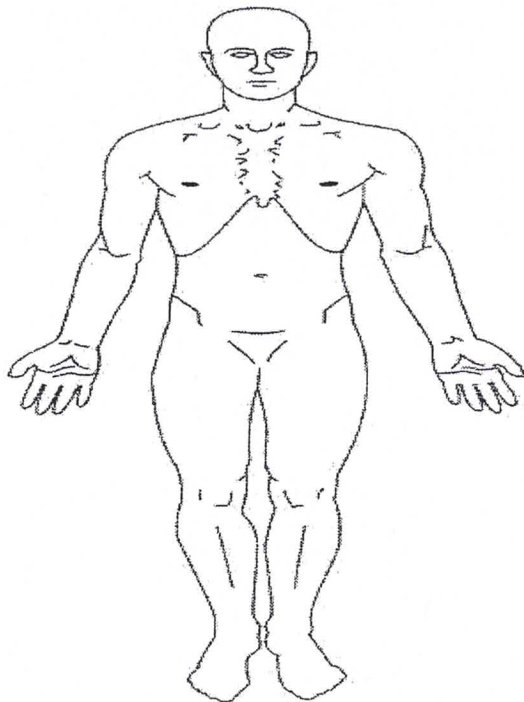
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin?

Month _____

Day _____

Year _____

Are your symptoms a result of:

Motor Vehicle Accident

Work related Accident

Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

What describes the nature of your symptoms?

Sharp
Burning

Dull ache
Tingling

Numb
Stabbing

Shooting
Other _____

Doctor's Signature _____

Patient Name _____

Date _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No	Difficulty Swallowing	Past	Present	
Irregular Heartbeat					Past	Present		Dizziness			
Swelling of legs				Glaucoma				Hearing Loss			
				Double Vision				Sore Throat			
Genitourinary			No	Blurred Vision				Nosebleeds			
	Past	Present						Bleeding Gums			
Kidney Disease				Psychiatric			No	Sinus Infections			
Burning Urination					Past	Present					
Frequent Urination				Depression				Gastrointestinal			No
Blood in Urine				Anxiety					Past	Present	
Kidney Stones				Stress				Gall Bladder Problems			
Lower Side Pain								Bowel Problems			
				Endocrine			No	Constipation			
Neurologic			No		Past	Present		Liver Problems			
	Past	Present		Thyroid				Ulcers			
Stroke				Diabetes				Diarrhea			
Seizures				Hair Loss				Nausea/Vomiting			
Head Injury				Menopausal				Bloody Stools			
Brain Aneurysm				Menstrual				Poor Appetite			
Numbness											
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

Doctor's Signature _____