

New Patient Intake Form

Patient Data

Date _____

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 _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | | |

Surgeries: (Check all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Other _____ | | | |

Allergies: (Check all that apply to you)

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: (Check all that apply to you)

- | | | | |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Chew Tobacco: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional | <input type="checkbox"/> always | <input type="checkbox"/> never |
| Other _____ | | | |

Family History: (Check all that apply)

- | | | |
|---------------|---------------------------------|----------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____ | | |

Occupational Activities: (Check one that best describes your job description)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> 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	Respiratory	Past	Present	Allergic/Immunologic	Past	Present
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		
Jaw Pain			Eyes				Past	Present
Irregular Heartbeat				Past	Present	Difficulty Swallowing		
Swelling of legs			Glaucoma			Dizziness		
			Double Vision			Hearing Loss		
Genitourinary			Blurred Vision			Sore Throat		
	Past	Present				Nosebleeds		
Kidney Disease			Psychiatric			Bleeding Gums		
Burning Urination				Past	Present	Sinus Infections		
Frequent Urination			Depression					
Blood in Urine			Anxiety			Gastrointestinal		
Kidney Stones			Stress				Past	Present
Lower Side Pain						Gall Bladder Problems		
			Endocrine			Bowel Problems		
Neurologic				Past	Present	Constipation		
	Past	Present	Thyroid			Liver Problems		
Stroke			Diabetes			Ulcers		
Seizures			Hair Loss			Diarrhea		
Head Injury			Menopausal			Nausea/Vomiting		
Brain Aneurysm			Menstrual			Bloody Stools		
Numbness						Poor Appetite		
Severe Headaches			Hematologic					
Pinched Nerves				Past	Present	Musculoskeletal		
Parkinson's			Hepatitis				Past	Present
Carpal Tunnel			Blood Clots			Gout		
Vertigo			Cancer			Arthritis		
			Bruising			Joint Stiffness		
Constitutional			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 and supplements

Doctor's Signature _____

Patient Name _____

Date _____

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

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

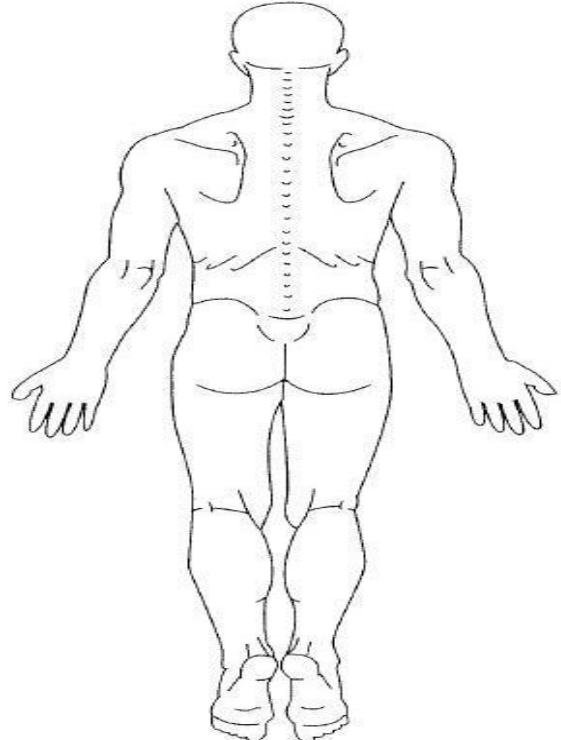
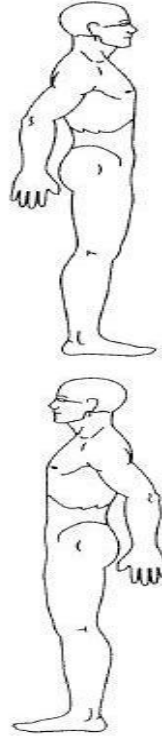
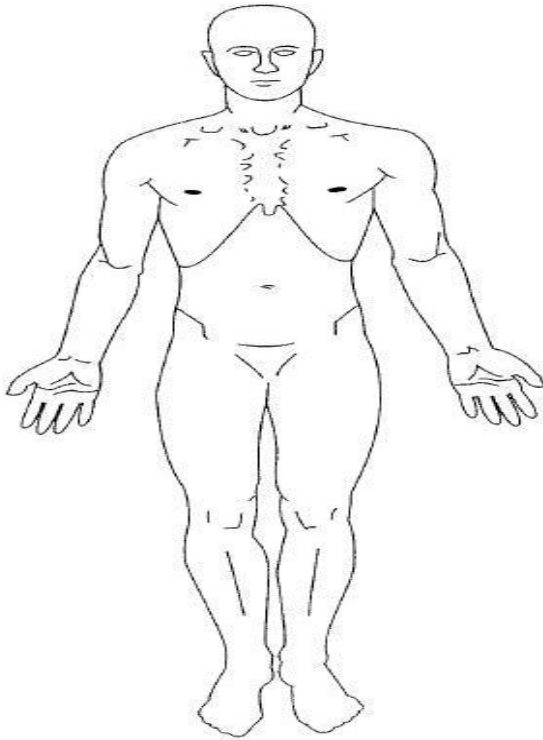
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Describe your symptoms in order of severity, List the pain level 1-10, with 10 being the worst

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 _____

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ **Score** _____

Description of Work: _____

Condition’s Effect On Job Performance: **No Effect** **Mild** (painful can do) **Mod** (painful limited ability)

Mod/Sev (limited duty) **Sev** (no limited duty) **Sev** (can’t do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Care –Infirm Family: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Carrying Groceries: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Change Posn–Sit-Stand: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Climb Stairs: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Driving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Extended Computer Use: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Feeding: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Household Chores: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Kneeling: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lift Children: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lifting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Pet Care: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Reading (Concentration): **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Bathing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Dressing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Shaving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sexual Activities: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sleep: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Standing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Walking: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Yard Work: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform

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:** _____