Intake Form Page 1

Name: ______________________ Date: ______________ Acct. #: ________

How did you hear about our office? ❑ Internet ❑ Sign ❑ Friend / Patient ❑ Advertisement ❑ Flyer ❑ Massage Event ❑ Other

If referred by a friend or patient, whom may we thank for their kind referral? ______________________

• All information is kept STRICTLY CONFIDENTIAL.
Please complete as accurately as possible. •

• ABOUT YOU •

❑ **Mr.** ❑ **Dr. (male)** ❑ **Mrs.** ❑ **Ms.** ❑ **Miss** ❑ **Dr. (female)**

Full Name: ______________________

Name you prefer we use: ______________________

Address: ______________________

City: ______________________

State: __________ **Zip:** __________

Date of Birth: ____ / ____ / ________ **Age:** ______

Email Address: ______________________

Home Telephone: (______) ________ - ________

Mobile Telephone: (______) ________ - ________

Employer: ______________________

Occupation: ______________________

Work Telephone: (______) ________ - ________

Marital Status: ❑ **Single** ❑ **Separated** ❑ **Divorced** ❑ **Married** ❑ **Widowed**

• FINANCIAL INFORMATION •

Name of the responsible party: ______________________ Patient's relationship to responsible party: __________

PRIMARY INSURANCE

Policy Holder's Name: ______________________ **Policy Holder's DOB:** __________

Ins. Co. Name: __________ Policy ID #: __________ Group #: __________

SECONDARY INSURANCE (if applicable)

Policy Holder's Name: ______________________ **Policy Holder's DOB:** __________

Ins. Co. Name: __________ Policy ID #: __________ Group #: __________

• EMERGENCY CONTACT •

Name: ______________________ Relationship: __________

Telephone: (____) ________ - ________ Alternate Telephone: (____) ________ - ________

• PERSON(S) AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION •

Name: ______________________ Relationship: __________

Telephone: (____) ________ - ________ Alternate Telephone: (____) ________ - ________

• PHYSICIAN •

Name of Primary Care Doctor: ______________________ Telephone: (____) ________ - ________

Address: ______________________

ACCOUNT INFORMATION

I hereby give my authorization/consent to treat me or my minor child as named herein on this form. Office policy requires **payment in full** for all services and goods rendered **at the time of my visit to the office**, unless other arrangements have been made. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable. I hereby authorize payment of any and all benefits, medical or otherwise, to the physician for benefits due me for the services and/or goods rendered. I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. **I understand the above information in its entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. In addition, I understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.**

______________________ __________
Patient Signature (Parent or Guardian Signature if Patient is a Minor) **Date Signed**

Name: ______________________ **Date:** ______________

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?______________

____

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

____

____

What have you tried that has relieved the pain or discomfort______________

____

What have you tried that has NOT worked? ______________

____

Is there anything that seems to aggravate your condition? ______________

____

Are there any additional areas or problems you would like addressed?______________

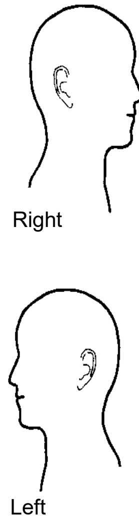
____

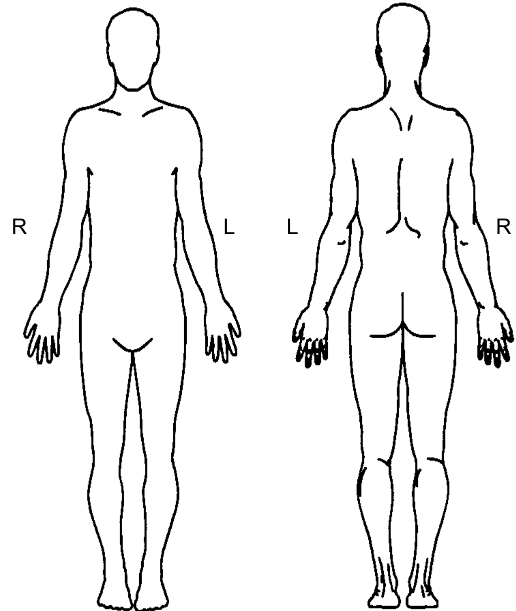
Name: ______________________________ **Date:** ____________

DESCRIBE YOUR PAIN OR DISCOMFORT

Please indicate **all** areas of pain or discomfort using the following symbols:

A = Aching	O = Constricting
B = Burning	P = Pounding
C = Cold	R = Throbbing
CR = Cramping	S = Stabbing
CU = Cutting	SH = Sharp
D = Dull	ST = Stinging
H = Hypersensitivity	T = Tingling
M = Spasm	X = Shooting
N = Numbness	Other = ____________





Please circle the level of pain and / or discomfort that most accurately describes this right now.

NO Pain 0 1 2 3 4 5 6 7 8 9 10 WORST Pain Imaginable

How often does it bother you?
- ❑ Up to 1/4 of awake time
- ❑ 1/4 to 1/2 of awake time
- ❑ 1/2 to 3/4 of awake time
- ❑ Most all of awake time

How much does it affect you?
- ❑ Does not affect daily activities
- ❑ Somewhat affects daily activities
- ❑ Seriously affects daily activities
- ❑ Prevents certain activities

When is pain worse?
- ❑ In the morning
- ❑ In the afternoon
- ❑ In the evening
- ❑ At bedtime

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: ____________

____

____

____

Name: ______________________________ **Date:** ____________

Health Questionnaire

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, stroke, aneurism, 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? ________________

Have you ever been diagnosed with any of the following ? Cancer, Diabetes, Heart Disease, Stroke, Pace Maker ?

____

____

Are you currently experiencing any nausea, vomiting, double vision, dizziness, or loss of vision

____

____

Name ________________________________ Date_____________________

(Circle L or R where appropriate.)	Have Now	Had in the Past	N/A
Neck Pain………………………………………	❑	❑	❑
Headaches / Migraines…………………………..	❑	❑	❑
High / Low Blood Pressure………………………	❑	❑	❑
Fatigue / Chronic Tiredness……………………..	❑	❑	❑
Dizziness………………………………………..	❑	❑	❑
Sinus Problems…………………………………..	❑	❑	❑
Allergies / Hay Fever…………………………….	❑	❑	❑
Buzzing / Ringing in Ears……………………….	❑	❑	❑
Earache / Ear Infections…………………………	❑	❑	❑
Deafness / Hearing Loss…………………………	❑	❑	❑
Shoulder / Arm / Hand Pain L / R…………….	❑	❑	❑
Numbness / Tingling in Arm / Hand L / R…..	❑	❑	❑
Carpal Tunnel Syndrome L / R………………	❑	❑	❑
Weakness in Grip L / R………………………..	❑	❑	❑
Thyroid Conditions……………………………….	❑	❑	❑
TMJ / Pain / Clicking……………………………..	❑	❑	❑
Mid Back Pain…………………………………	❑	❑	❑
Asthma / Difficulty Breathing / Wheezing………	❑	❑	❑
Chest Pain / Heart Conditions…………………..	❑	❑	❑
Emphysema………………………………………	❑	❑	❑
Recurrent Lung Infections / Bronchitis…………	❑	❑	❑
Indigestion / Heartburn / Stomach Problems…..	❑	❑	❑
Scoliosis…………………………………………..	❑	❑	❑
Skin Conditions / Acne / Eczema………………	❑	❑	❑
Low Back Pain…………………………………..	❑	❑	❑
Hip Pain / Sciatica L / R………………………..	❑	❑	❑
Pain in Leg / Foot L / R………………………..	❑	❑	❑
Numbness / Tingling in Leg / Foot L / R…….	❑	❑	❑
Joint Problems……………………………………	❑	❑	❑
Constipation / Diarrhea / Colon Disease……….	❑	❑	❑
Bladder Problems…………………………………	❑	❑	❑
Menstrual Pain / P.M.S…………………………..	❑	❑	❑
Varicose Veins L / R…………………………..	❑	❑	❑
Arthritis - Osteo / Rheumatoid…………………..	❑	❑	❑
Cancer……………………………………………..	❑	❑	❑
High / Low Cholesterol…………………………..	❑	❑	❑
Pinched Nerves…………………………………..	❑	❑	❑
Poor Circulation…………………………………..	❑	❑	❑
Decreased Range of Motion…………………….	❑	❑	❑
Seizures……………………………………………	❑	❑	❑
Muscle Spasms / Muscle Cramps………………	❑	❑	❑
Sprains / Strains…………………………………..	❑	❑	❑
Stress / Tension…………………………………..	❑	❑	❑
Tendonitis…………………………………………	❑	❑	❑
Tight Muscles……………………………………..	❑	❑	❑
Disc Problems…………………………………….	❑	❑	❑
Diabetes……………………………………………	❑	❑	❑
Fibromyalgia………………………………………	❑	❑	❑
Stroke………………………………………………	❑	❑	❑

Other __________________..........................

I certify that all the information contained in this packet is true and complete to the best of my knowledge

Signature

____

Printed Name

____

Date

____