



**NEW PATIENT INTAKE FORM**

**Patient File #:** \_\_\_\_\_

**Today's Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PERSONAL INFORMATION:**

Name: (First)\_\_\_\_\_ (Middle Initial)\_\_\_\_\_ (Last)\_\_\_\_\_ Jr., II, III, IV

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Marital Status (Circle): Divorced Married Single Separated Widowed

Do you have children?  Yes  No If yes, # of children \_\_\_\_\_

Gender (Circle): Male / Female Home Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

**Employer /Employment Status** Employed Unemployed Full Time / Part Time Student Other

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_

Is it ok to contact you at work?  Yes  No

**Emergency Contact Information**

Name: (First)\_\_\_\_\_ (Middle Initial)\_\_\_\_\_ (Last)\_\_\_\_\_ Jr., II, III, IV

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

**PAYMENT/INSURANCE INFORMATION:**

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

Yes  No

Who besides yourself is responsible for your bill?

Self-Pay Health Insurance Medicare Medicaid Worker's Comp Auto Insurance

Other (Be Specific): \_\_\_\_\_

Auto or Workers' Comp Insurance Carrier & Claim #: \_\_\_\_\_

**COMPLAINTS:**

**WHEN DID IT START?**

1.	
2.	
3.	
4.	
5.	
6.	



**LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:**

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**LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:**

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**LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:**

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**ASSOCIATED Complaints:**

- Ring in Ears     Yes    No     Left     Right             Both Ears
- Blurry Vision     Yes    No     Left     Right             Both Eyes
- Nausea/vomiting     Yes    No
- Headaches             Yes    No
- Depression    Nervousness    Fatigue    Anxiety    Excessive irritability
- Fear of driving in a car    Loss of concentration    Jaw clenching    Dizziness
- Nightmares

**Numbness/Tingling:**

- Left Hand             Left Upper Arm     Right Hand             Right Upper Arm
- Left Foot             Left Leg             Right Foot             Right Leg

**ACCEPTANCE AS A PATIENT:**

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins. I understand and agree that this office has the right to terminate my care as a patient if I do not follow the prescribed treatment for my condition. I understand and agree that I might be referred to another health provider as the doctor deems medically necessary.

\_\_\_\_\_  
**PATIENT PRINTED NAME**

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**