Welcome To Our Office

Personal Information: Today's Date: _____/_____/_____ File #: _____

Name: _____ □ Male □ Female

Birth date: _____/_____/_____ Age: _____ SSN: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

E-mail address: (for monthly newsletter/correspondence only) _____

How did you hear about us? □Referral □Mail □Location □Internet □Walk-in □Insurance □Internet_____

Who may we thank for referring you to our office? _____

Employer: _____ How Long? _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: _____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Emergency Contact: _____ Phone #: _____

Relation: _____ Medical Physician's Name: _____

Insurance Information:

Do you intend to use health insurance? □ No □ Yes Are you covered by: □ Medicare

****Please allow our front desk staff to copy your insurance card and drivers' license*****

Account Information:

Person ultimately responsible for account: ☐ Same as listed above (if different please complete below)

Name: _____ Relation: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ D.L. # _____

Home Phone: _____ Work Phone: _____

Payment Information:

PLEASE NOTE: On your first visit, payment is due in full at the time of service, unless prior arrangements were made. We **DO** accept insurance assignment, but **NOT** until we are able to contact your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request.

Based on this, payment today will be: _____Cash _____Check _____Credit Card (Visa, MC)

I authorize the doctor to evaluate and care for me as he/she deems appropriate. I understand and agree that all services rendered me at this office are my financial responsibility and are charged directly to me. Even if submitted to insurance, ultimately I am personally responsible for payment.

Patient Signature _____ Date: _____/_____/_____

Parent/Guardian Signature _____ Date: _____/_____/_____

Patient Intake Form

For Office Use Only
Date: ____________________
Acct #:___________________

Name: ____________________________________

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ______________________________
Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ______________________________________
Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ________________
Briefly describe the accident, injury or illness:____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
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List any tests, studies or medications received for this condition:
❑Tests/Studies: ____
❑Medications: ____
Where you admitted to the hospital due to this condition: ❑Yes ❑No
If yes, what hospital? ______________________Transported by? ❑Ambulance ❑Police ❑Other: ____________________
Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________
List the hospital procedures received: ____

List symptoms you are experiencing today: **Choose the severity level associated with each symptom**

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
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Do you have any current work restrictions due to this condition?
Off work: ❑Yes ❑No ❑Previously From: ___________________ To: ____________________
Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ___________________________________
What type of work do you do?____

____

Name: _____ File #: _____ Date: _____/_____/_____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

List any past conditions you may have had: _____

HABITS

❑Smoking Packs/day: _____

❑Drinking Alcohol: (Cups/day): _____

❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____

❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑_____
Father	❑	❑	❑	❑_____
Brother(s)	❑	❑	❑	❑_____
Sister(s)	❑	❑	❑	❑_____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? ❑Yes ❑No
If yes, which ones?: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies? ❑Yes ❑No If yes, please explain: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

❑ Allergy(What) ____
_____
❑ Bronchitis
❑ Chills (Constant)
❑ Convulsions
❑ Dizziness
❑ Fainting
❑ Fatigue
❑ Headache

GASTRO-INTESTINAL

❑ Belching or Gas
❑ Colon Trouble
❑ Constipation
❑ Diarrhea
❑ Gall Bladder Trouble
❑ Hemorrhoids (piles)
❑ Jaundice
❑ Liver Trouble
❑ Nausea

EYE/EAR NOSE/THROAT

❑ Asthma
❑ Deafness
❑ Earache
❑ Ear Discharge
❑ Ear Noises
❑ Thyroid Problems
❑ Frequent Colds
❑ Hay Fever
❑ Nasal Obstruction

RESPIRATORY

❑ Chest Pain
❑ Chronic Cough
❑ Difficulty Breathing
❑ Spitting Blood
❑ Spitting Phlegm

GENITO-URINARY

❑ Bed Wetting
❑ Blood in Urine

Name: _____ File #: _____ Date: _____/_____/_____

GENERAL SYMPTOMS

- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

GENITO-URINARY

- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors
- ❑ Twitching

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____