New Patient Intake Form

How did you hear about this office? ______________________________

Name: ______________________ SS#: ______________ DOB: ________ Age: _____

Home Address: ______________________ City: ______________ State: ____ Zip: ________

Home Phone: ______________ Cell Phone: ______________ E-Mail: ________________

Work Phone: ______________ Work Status: *FT • PT • Ret • Not* Sex: *M-F* Marital Status: *S-M-D-W*

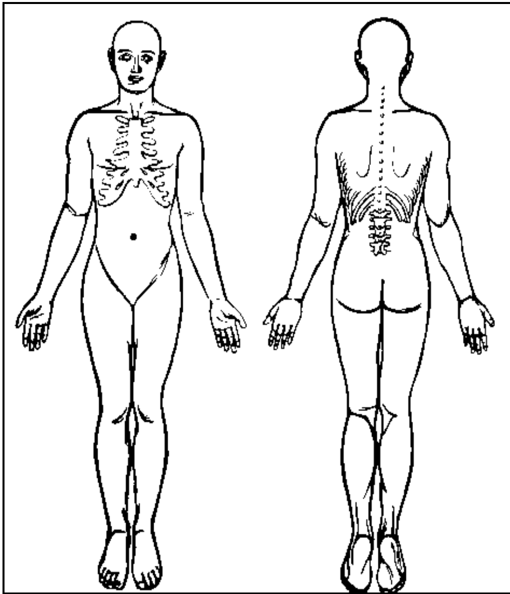
Occupation: ________________ Employer: ________________ Job Stress: *High-Moderate-Low*

Sports and Hobbies: ______________________________

Family Doctor and/or Group Name & Location: ______________________________

Please indicate the area and nature of your complaint(s) on the diagram below:

S = Sharp, **D** = Dull, **P** = Pins and Needles, **N** = Numb, **B** = Burning, **T** = Throbbing, **C** = Cramping



Please describe your complaint(s): ______________________________

____

____

Indicate the *current* pain level of each complaint on the scale below:

(No Pain) 0---1---2---3---4---5---6---7---8---9---10 (Unbearable)

Is it *constant* or does it *come and go*? ________________

Is it getting progressively worse? ________________

When does it hurt the most? ________________

When did you first notice this problem? ________________

What activity were you performing? ________________

What makes it feel better? ________________

What makes it feel worse? ________________

Prior treatment(s) for this condition: ☐ None ☐ Medication ☐ Physical Therapy ☐ Surgery ☐ Other

Have you been under chiropractic care in the past? ☐ Yes ☐ No Name: ________________

List all medications you are currently taking: ______________________________

List all hospitalizations and surgeries: ______________________________

List all falls, accidents and traumas: ______________________________

By signing below:

- You attest that the above information is true and accurate to the best of your knowledge.
- You attest that a copy of the *Notice of Privacy Practices* has been provided (upon request).
- You authorize payment of your medical benefits to this office for services rendered to you.
- You authorize the release of any information that is necessary to process an insurance claim.
- You acknowledge that in the event of insurance non-payment, financial responsibility is ultimately yours.
- You acknowledge repeatedly missing appointments (no shows or late cancellations) will be subject to a $25 FEE.

Signature: ______________________________ Date: ________________