New Patient Intake Form

How did you hear about this office? ____

Name: ______________________ E-Mail: ______________________ DOB: __________

Home Address: ______________________ City: ______________ State: _____ Zip: __________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ________________

Work Status: *Full Time • Part Time • Retired • Student • None* Sex: *Male-Female* Marital Status: *S-M-D-W*

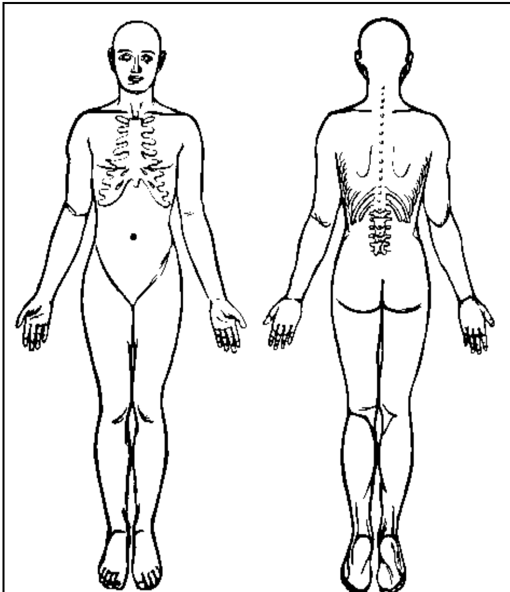
Occupation: ________________ Employer: ________________ Job Stress: *High-Moderate-Low*

Sports and Hobbies: ____

Family Doctor 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



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

Received chiropractic care in the past? ☐ Yes ☐ No Name: ______________________

Current medications: ____

Hospitalizations and surgeries: ____

Falls, accidents and traumas: ____

By signing below:

- You affirm that the above information is true and accurate to the best of your knowledge.
- You affirm 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: ________________