NEW PATIENT INTAKE FORM

TODAY'S DATE _____ / _____ / _____

PAYMENT TYPE: Insurance ☐ Cash ☐ Personal Injury ☐

NAME: (LAST) ______________________________ (FIRST) ______________________

BIRTH DATE: _______ / _______ / ______ AGE: ________ GENDER: _____

HEIGHT: _________ FT. ________ IN. WEIGHT: _____________________ LBS

ADDRESS: ____ APT: ________

CITY: ____________________________ STATE: __________ ZIP: ___________

PHONE: (_____) _______________ E-MAIL: _____________________________

REASON FOR SEEKING CHIROPRACTIC CARE

REASON(S) FOR CARE (circle all that apply) : Wellness Care Neck Pain Mid Back Pain

Low Back Pain Shoulder Pain Elbow Pain Wrist Pain Hip Pain Knee Pain

Ankle Pain Headaches Sore / Tight Muscles Weakness Decreased Range of Motion

PAIN STARTED _____ DAY(S) / WEEK(S) / YEAR(S) GETTING = BETTER / WORSE / SAME

WHAT MAKES IT FEEL BETTER: ____

WHAT MAKES IT FEEL WORSE: ____

QUALITY OF PAIN (I.E. ACHY, NUMB, SHARP) ____________________________________

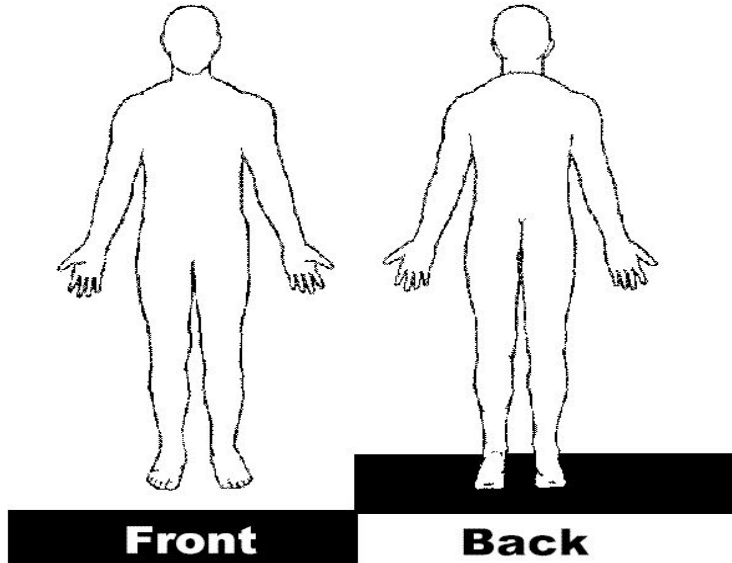
PAIN SCALE (1 = NO PAIN / 10 = WORST PAIN I HAVE EVER FELT)

1 2 3 4 5 6 7 8 9 10

THE PAIN IS WORSE IN: (I.E. MORNING, EVENING) _______________________________

PAIN OCCURS (circle one): 1-25% / 26 - 50% / 51% -75% / 76%- 100% of the time

CIRCLE AREA(S) OF PAIN ON BODY
INDICATE IF PAIN MOVES TO OTHER AREAS BY DRAWING AN ARROW



PREVIOUS CHIROPRACTIC CARE

PREVIOUS CHIROPRACTOR: ____

SPINAL X-RAYS TAKEN: Y N DATE OF SPINAL X-RAYS ______ / ______ / ______

REASON FOR CARE: ____

OTHER HEALTHCARE PROVIDERS

NAME: ________________________________ TYPE (MD, DO, PT): ____________

REASON FOR CARE: ____

RESULTS: ____

REFERRAL INFORMATION

HOW DID YOU DISCOVER POFF CHIROPRACTIC & REHABILITATION?

____

CURRENT EMPLOYER

NAME: ______________________________ JOB TITLE: ________________________

ADDRESS: ____

PHONE: (________) ______________________________

RESPONSIBILITIES: ____

HOBBIES / LEISURE ACTIVITIES

TYPE OF ACTIVITY FREQUENCY

____

____

____

SOCIAL HISTORY

MARITAL STATUS: ______________________ NUMBER OF CHILDREN: ___________

SMOKER: Y N IF YES, HOW MANY PACKS PER DAY: ____________

CONSUME ALCOHOL: Y N IF YES, HOW MANY DRINKS PER WEEK: _________

HOURS OF SLEEP PER NIGHT: ______ QUALITY OF SLEEP: GOOD / FAIR / POOR

ABNORMAL WEIGHT CHANGES: Y N IF YES, HOW MANY LBS: _______ ↑ OR ↓

FAMILY HISTORY

DIABETES: Y N FAMILY MEMBER: _____________________________

CANCER: Y N TYPE: ____________ FAMILY MEMBER: _______________

HEART CONDITIONS: Y N FAMILY MEMBER: _____________________________

ANY OF THESE FAMILY MEMBERS DECEASED: Y N NAME: ____________________

Poff Chiropractic & Rehabilitation LLC
315 E. Broad St
Greenville, SC 29601

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: (________________) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Poff Chiropractic & Rehabilitation and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Poff and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

____
Print Patient's Name

____
Signature of Patient

_______/________/_________________
Date

To be completed by patient's representative:
(e.g. if the patient is a minor or is physically or mentally incapacitated)

____
Print Name of Representative

____
Signature of Representative

_______/________/_________________
Date

Physician Signature _____________________________ Date _____/_____/___________