Chiropractic Intake Form.... **Cathryn Woon DC**

Patient Information

Thank you for choosing our practice for chiropractic needs. Please complete this form in ink.
(Please Print)

Name______________________________ Date_______ HIC/patient ID#___________________
first middle initial Last
Address_______________________ City__________________state_____ Zip_____________
Sex: O Female O Male Birthdate_________________ Email_____________________________
Home Phone( ) ______________ Cell Phone( )___________Work Phone ( )_________
Do you prefer to receive calls at: O Home O Work O Cell O no preference
O Married O Widow O Single O Minor O Separated O Divorced O Partnered for___ years
Patient employer/School_____________________________________ Occupation______________
Employer/school Address____________________ City__________State_____Zip______________
Spouse or parents name______________ Employer____________Work Phone( )___________
Whom may we thank for referring you to us?____
Person to contact in case of emergency__________________________Phone( )_____________

Responsible Party

Name of person responsible for this account ____
Relationship to Patient_____________________________________ Phone( )_______________
Address____ City_____ State_______ Zip_______
Name of Employer__________________________________ Work Phone( )________________

Insurance Information

Name of insured_______________________________ Relationship to patient _________________
Birthdate______________________________________ Date Employed_______________________
Name of employer______________________________Work Phone( ) ____________________
Address_______________________________ City___________ State__________Zip__________
Insurance Co.______________ Phone( )_____________ Group#____ Employer#___________
Insurance Co. Address_____________________ City __________ State________ Zip___________
How much is your deductible?_____ How much have you used?_____ Max. annual benefit?____
DO YOU HAVE ADDITIONAL INSURANCE? O No O Yes IF YES PLEASE COMPLETE THE FOLLOWING
Name of insured_______________________________ Relationship to patient _________________
Birthdate______________________________________ Date Employed_______________________
Name of employer______________________________Work Phone( ) ____________________
Address_______________________________ City___________ State__________Zip__________
Insurance Co.______________ Phone( )_____________ Group#____ Employer#___________
Insurance Co. Address_____________________ City __________ State________ Zip___________
How much is your deductible?_____ How much have you used?_____ Max. annual benefit?____

Symptoms

Reason for visit__________________________ When did you first notice the symptoms_______
is this condition getting any worse?____
Where specifically is the problem(s) located?____
Which activities are difficult to perform O Sitting O standing O Walking OBending down
O lying down O other
Type of pain O sharp ODull O Throbbing O numbness OAching Oshooting O burning
O Tingling O Cramps O stiffness O swelling O other

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Rate the severity of your pain. (1 mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go______________________________
What treatment have you already received for your condition?
O medication O Surgery O Physical therapy O other____________________
Name and address of other doctor(s) who have treated you for your condition:

____

Health History

Check only those which are applicable:

O AIDS/HIV	O Chicken pox	O Herpes	O Pneumonia	O Typhoid Fever
O Alcoholism	O Depression	O High Cholesterol	O Polio	O Ulcers
O Allergy Shots	O Diabetes	O Kidney Disease	O Prostate Problems	O Vaginal Infections
OAnorexia	O Emphysema	O Liver Disease	O Prosthesis	O Venereal Disease
O Appendicitis	O Epilepsy	O Measles	O Psychiatric Care	O Whooping Cough
O Arthritis	O Fractures	O Migraine Headaches	O Rheumatoid Arthritis	O Other
O Asthma	O Glaucoma	O Miscarriage	O Rheumatic Fever	________________
OBleeding disorder	O Goiter	O Mononucleosis	O Scarlet Fever	________________
OBreast lump	O Gonorrhea	O Multiple Sclerosis	O Stroke	
O Bronchitis	O Gout	O Mumps	O Suicide Attempt	
O Bulimia	O Heart disease	O Osteoporosis	O Thyroid Problems	
O Cancer	O Hepatitis	O Pacemaker	O Tonsillitis	
O Cataracts	O Hernia	O Parkinson's Disease	O Tuberculosis	
O Chemical Dependency	O Herniated Disc	O Pinched Nerve	OTumors, Growths	

Date of last exams____
(Woman)Are you pregnant? OYes ONo Nursing? OYes ONo Taking birth control pill? OYes O No
list any type of surgeries which you had and the dates which they occurred:__________________
____
Please list all medications you are currently taking? ______________________________
Allergies:____

Daily Habits

What type of exercise do you perform on a daily basis? O None O Moderate O Heavy
What do your daily work habits include?(ex:sitting, standing, light labor, heavy labor, computer work)____

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What vitamins do you currently take?____
what kind of other nutritional supplements do you take(if any)?____________________________
Do you smoke? O Yes O No How much per day?_____________________________
How much liquor do you consume on a weekly basis?____________________________
How much coffee or caffeinated beverages do you consume on a daily basis?________________

Certification and Assignments

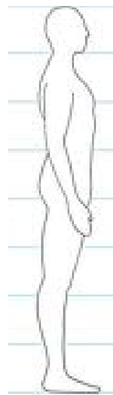
To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with______________________
Name of Insurance Company(ies)
and assign directly to Dr.____________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ________________________
signature of patient, parent, guardians or Personal Representation Date

Circle Area of Problem.



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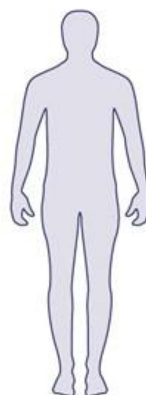

FRONT

BACK