RiverPark Chiropractic and Acupuncture

4922 Brainerd Road
Chattanooga, TN 37411
(432) 710-2656

NEW PATIENT INTAKE (WEB)

Personal Information

Patient____Date_______________________

Date of Birth______/____/_______ Social Security#____

Address____________________________________City_________________State________Zip_________

Telephone____________________________________ Work phone________________________________

Email____ Sex: M F

Work Information

Occupation____Employer_____________________________

Address____________________________________City_________________State________Zip_________

Insurance Information

Company_____________________________SubscribersID___________________DateofBirth___/___/___

Subscribers SS#_____________________________Relationship_____________Group#______________

Referred to this OFFICE by____

Primary Physician____

Address__________________________________City________________State__________Zip__________

Reason for Today's visit:____

Check one:

Emergency___ New Injury ___Flare up ___ Chronic Pain ___Wellness____

Are you in pain now? Yes____ No____

Rate your pain (10 the worst Imaginable ---0 no pain) _____________

Did you have an injury? Yes ___No___ If so describe____
____
____
Date of the complaint started___________________________. Explain Onset______________________

Is this complaint related to an Auto Accident___ Work Injury___?
Explain
Details____
____
Is the condition getting worse? Yes__ No__
Is your condition interfering with your work? Yes__ No__
Have you been treated by a Medical Physician for the complaint? Yes__ No__
Have you been treated by Chiropractor Physician for this complaint? Yes__ No__
May we request records? Yes__ No__
Please indicate current /past medications?
____
____
Please indicate current/past surgeries/therapy utilized and Dates? _______________________________
____
Do you have or have you had any of the following medical conditions?
Heart Attack/Stroke Yes__ No__ Anemia/Diabetes Yes__ No__
Glaucoma Yes__ No__ Rheumatic Fever Yes__ No__
Fainting Yes__ No__ Arthritis Yes__ No__
Kidney/Urinary DX Yes__ No__ Headaches Yes__ No__
Cancer/TB/ Colitis Yes__ No__ Difficulty breathing Yes__ No__
Heart Defects Yes__ No__ Psychiatric DX Yes__ No__
Asthma/Emphysema Yes__ No__ H/L Blood pressure Yes__ No__

We invite you to discuss with us any questions regarding our services. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to information I have provided.

Signature____Date_____________________
Parent or Guardian ____Date______________________