New Patient Intake Forms

1 Patient Information

Name: _____
(First) *(MI)* *(Last)*

Address: _____

_____
(City) *(State)* *(Zip)*

Birthday: _____ Age:____ ☐ Male ☐ Female

Social Security #: ____ / ____ / ____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Parent's Name *(if minor)*: _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Spouse's Name: _____

Referred by:_____

2 Insurance

Who is responsible for this account?: _____

Relationship to patient: _____

Insurance company: _____

Insurance Employer _____

Insurance ID number: _____

Group / Claim Number: _____

Are you covered by additional insurance? ☐ Yes ☐ No

Insurance company: _____

Insurance ID number: _____

Group / Claim Number: _____

Birthdate of Insured: _____

Please present insurance card(s) so we can put a copy in your file

3 Accident Information

Is your condition due to an accident? ☐No ☐Yes ☐Date: _____

Type of accident? ☐ Automobile ☐Work ☐Slip-and-Fall

Who have you reported the accident to? ☐Insurance Co.

☐ Worker's Comp ☐Employer ☐Other: _____

Attorney Name *(if applicable)*: _____

4 Contact Information

Home Phone: _____

Cell Phone: _____

Work Phone: _____ Ext: _____

Email: _____

Best way to reach you: ☐Home ☐Cell ☐Work ☐Email

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

5 Patient Condition

What is your major symptom / problem?: _____

When did your symptoms begin?: _____

Have you had this problem before? ☐Yes ☐No

Is your condition getting worse? ☐Yes ☐No

Is this problem: ☐ Constant ☐ Comes and Goes

Describe your pain *(Check all that apply)*
☐Burning ☐Sharp ☐Shooting ☐Dull ☐Aching ☐Stiffness

☐Tingling ☐Throbbing ☐Swelling ☐Other: _____

Circle below the severity of your pain on a scale of 1-10

(No pain) **1 2 3 4 5 6 7 8 9 10** *(Severe pain)*

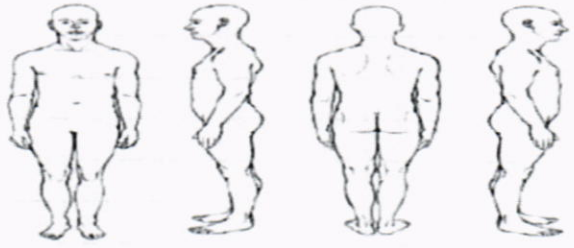
What makes your condition better?: _____

What makes your condition worse?: _____

How often do you experience your symptoms? Indicate where you have pain or other symptoms

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

Please mark where it hurts with an X:



When are you most in pain? ☐Morning ☐Afternoon ☐Evening ☐While sleeping ☐Constantly

Does it interfere with your... ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Exercise Routine

Activities/movements that are painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down ☐Driving ☐Reading ☐Getting up

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Health History

What other treatments have you had for this condition? And When?

☐ Chiropractic ____ ☐ Orthopedic ____ ☐ Neurologist ____ ☐ Physical Therapy ____ ☐ Medication ____ ☐ Surgery

☐Acupuncture ____ ☐ Nutrition ____ ☐ Massage ____ ☐ Personal Training____

Name of other doctors who have treated you for your condition:_____

Females: Are you pregnant? ☐Yes ☐ No

Check any of the following conditions that you / your family have had:

Family/Self		Family/Self		Family/Self	
☐	☐ AIDS / HIV	☐	☐ Ear Ringing	☐	☐ Neck Pain
☐	☐ Allergies	☐	☐ Epilepsy	☐	☐ Osteoporosis
☐	☐ Anxiety / Depression	☐	☐ Headaches	☐	☐ Poor Circulation
☐	☐ Arm / Shoulder Pain	☐	☐ Headaches (Migraines)	☐	☐ Prostate problems
☐	☐ Arthritis	☐	☐ Heart Disease	☐	☐ Rheumatoid Arthritis
☐	☐ Asthma	☐	☐ Hemorrhoids	☐	☐ Sciatica
☐	☐ Bladder Problems	☐	☐ Herniated Disc	☐	☐ Shingles
☐	☐ Cancer	☐	☐ High Blood Pressure	☐	☐ Sinus Infections
☐	☐ Chronic Fatigue	☐	☐ Insomnia	☐	☐ Stroke
☐	☐ Deafness	☐	☐ Irregular Cycle	☐	☐ Thyroid Problems
☐	☐ Diabetes	☐	☐ Kidney Problems	☐	☐ TMJ
☐	☐ Digestion Problems	☐	☐ Leg Pain	☐	☐ Venereal Disease
☐	☐ Earache	☐	☐ Low Back Pain	☐	☐ Vertigo / Dizziness
☐	☐ Chest Pain/ Heaviness	☐	☐ Shortness of breath	☐	☐ Memory Loss
☐	☐ Difficulty concentrating	☐	☐ Fatigue		

What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:*_
☐ MRI *date:*
☐ CT Scan *date*
☐EMG/NCV *date*
☐ Other *date:*

Stressors

☐ Smoking Packs/Day: _____
☐ Alcohol Drinks/Week: _____
☐ Coffee/Caffeine Drinks Cups/Day: _____
☐ High Stress Level Reason: _____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Tolerance

☐ Same
☐ Increasing
☐ Decreasing

Have you had any:	Description	Date
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken Bones	_____	_____
Falls / Head Injuries	_____	_____

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Medications and Allergies

What allergies do you have or have you had in the past? *Include all seasonal and medication related allergies.*

_____

Complete list blow to inform the office of any medications, vitamins, herbs, and/or supplements that you are currently taking. Be sure to complete all fields within the table.

Medication/Vitamin/Herb/Supplement	Strength	Dosage/Frequency