NEW PATIENT INTAKE

Please Print all information

Date___/____/____

Name_____ _____ _____ M ☐ F ☐

Social Security Number_____-_____-_____ Birth Date____/_____/_____

Address_____ City _____ST _____ Zip_____

Home Phone ( ) _____Cell ( ) _____ Work ( )_____

Email Address _____ @_____

Employer Name_____

Employer Address_____Occupation_____

Primary Care Physician_____ Phone # ( ) _____

Single☐ Married ☐ Divorced ☐Widowed ☐

Spouse's Name _____ Spouse Birth Date ____/____/_____

Emergency contact Person _____ Relationship ____ Phone ( ) _____

Ever had this same condition? ☐ Yes ☐ No

Is today's visit due to an accident or injury? ☐ Yes ☐ No

If yes, date of injury/symptoms_____

Did you go to the emergency room for this injury? ☐ Yes ☐ No

What hospital? _____

Have you been treated by a Chiropractor before? ☐ Yes ☐ No

If yes, when?_____

Whom may we thank for referring you to our office? _____

☐_____ **(If no insurance, please initial)** I do not have health insurance and wish to receive time-of-service fees. I understand that the reduced fee is offered to non-insured patients and is extended to those with current accounts only. Past due accounts will be billed at the regular rate.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and or other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 15%.

_____ **Date** _____/_____/_____

Patient Signature

_____ **Date** _____/_____/_____

Parent/Guardian Signature

NEW PATIENT INTAKE

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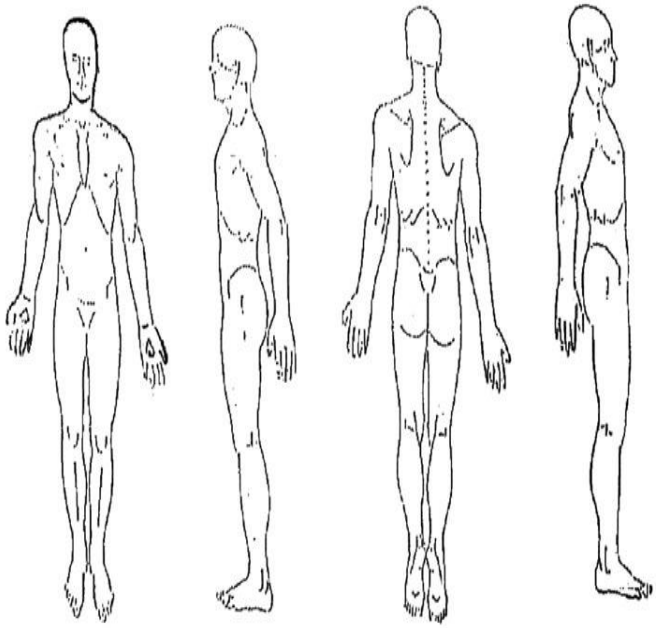
YOUR HEALTH SUMMARY

Please check all symptoms you have ever had, even if they do not seem related to your current problem.
For today's visit, circle areas of concern on the diagram.

☐Headaches
☐Fainting
☐Pins and needles in arms
☐Back Pain
☐Dizziness
☐Ringing in ear
☐Numbness in fingers
☐Loss of taste
☐Fatigue
☐Irritability
☐Sleeping problems
☐Cold hands
☐Diarrhea
☐Fever
☐Cold sweats
☐Problem urinating
☐Mood swings
☐Menstrual irregularity/pain

☐Pins and needles in legs
☐Neck Pain
☐Loss of smell
☐Loss of balance
☐ Ulcers
☐Nervousness
☐Numbness in toes
☐Stomach upset
☐Depression
☐Tension
☐Neck stiff
☐Cold feet
☐Constipation
☐Hot flashes
☐Lights bother eyes
☐Heartburn
☐Diabetes



Are you currently experiencing any of the symptoms above? If yes, which ones? _____

Date of last physical exam _____ Any chance that you are pregnant? ☐ Yes ☐ No
Check what best describes your condition right now?
Type of pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Spasm ☐Numb ☐Tingling ☐Shooting
What activities aggravate your symptoms? _____
Is there anything that relieves your symptoms? ☐ Yes ☐ No Describe_____
_____
Does the pain radiate into your ☐Arm ☐ Leg ☐Does not radiate.
Is this condition getting worse? ☐ Yes ☐ No
Does this complaint interfere with ☐Work ☐Sleep ☐Hobbies ☐Daily routine
Explain:_____
Do you exercise? ☐ Yes ☐ No How often? 1X 2X 3X 4X 5X per week Other: _____
What activities? ☐Running/Jogging ☐Weight Training ☐Cycling ☐Yoga ☐Pilates ☐Swimming _____
Do you wear orthotics? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

List any medications, herbs and/or vitamins & dosage you are currently taking _____
_____

Have you ever:		Briefly Explain
Broken any bones?	☐ Yes ☐ No	_____
Been hospitalized?	☐ Yes ☐ No	_____
Been in an auto accident?	☐ Yes ☐ No	_____
Been struck unconscious?	☐ Yes ☐ No	_____
Had Surgery?	☐ Yes ☐ No	_____
Had x-rays taken?	☐ Yes ☐ No	_____

NEW PATIENT INTAKE

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NOTICE OF PRIVACY PRACTICES AND INFORMED CONSENT FOR EXAMINATION AND TREATMENT ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

Patient Name (***please print***) _____ Birth Date _____

I acknowledge that I was provided with a copy of the *Back2Health* Notice of Privacy Practices.

✓ Patient Signature _____ _____

(if under 18) parent/guardian's signature & relationship) *Relationship*

I acknowledge that I was provided with a copy of the *Back2Health* Informed Consent for Examination and Treatment.

✓ Patient Signature _____ _____

(if under 18) parent/guardian's signature & relationship) *Relationship*

FEMALE PATIENTS:

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual cycle: _____

✓ Patient Signature _____ _____

(if under 18) parent/guardian's signature & relationship) *Relationship*

PERSONAL INFORMATION AUTHORIZATION

I authorize the following individual(s) to have access to my records as necessary.

_____	_____	_____
Name	Phone #	Relationship
_____	_____	_____
Name	Phone #	Relationship

For *Back2Health* use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of *Back2health*'s Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign

☐ Patient unable to sign

☐ Other _____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record