MY CHIROPRACTIC DOCTOR

New Patient Intake Form

Patient Information

Full Name _____ **Nickname** _____ **Date** _____
First MI Last

Address _____**City** _____ **State** _____ **Zip** _____

Age _____ **Date of Birth** _____ **Sex** □ Male □ Female **Marital Status** □ Single □ Married □ Other

SS # _____ **Email** _____ **I prefer to receive calls at** □ Home □ Work □Cell

Home Phone _____**Work Phone** _____**Cell Phone** _____Cell Provider_____

Employer _____ **Occupation** _____

Spouse Name _____ **Spouse Cell Phone** _____

Primary Language Spoken_____ Race_____ Ethnicity_____

Emergency Contact _____ **Relationship** _____ **Contact Phone** _____

How did you hear about us? □Location □Internet □Marketing Ad □Patient Referral (_____) □Other _____
Name

Payment Information

Person Responsible for Payment _____ **Date of Birth** _____ **Phone** _____

SS# _____ **Do you have health insurance?** □ Yes □ No **Are you the Policy Holder?** □ Yes □ No

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Policy Holder's Name	Policy Holders Name
Relationship to Patient	Relationship to Patient
Policy Holder's Birth Date	Policy Holder's Birth Date
Group Number	Group Number
Policy ID Number	Policy ID Number

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release- By signing below, I authorize My Chiropractic Doctor to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to My Chiropractic Doctor and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations.

By signing below, I give my consent for examination and the performances any testes or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Patient/Guardian Signature _____ **Date** _____

Health Questionnaire

Patient Information

Full Name _____ **Date of Birth** _____ **Height** _____ **Weight** _____

Medical History

Describe the reason for your visit _____

When did your symptoms begin? _____ **How did your symptoms begin?** _____

How often do you experience your 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)

Describe your symptoms? □ Sharp □ Dull ache □ Numb □ Shooting □ Burning □Tingling □ Stabbing

How are your symptoms changing? □ Getting better □ Staying the same □ Getting worse

Are your symptoms affecting your daily activities? □ Severe (Unable to Perform) □ Moderate (Painful/Limited) □ Mild (Painful/Can Do) □ No Effect (Discomfort)

On a scale of one to ten how intense are your symptoms? **(**Not intense) 0 1 2 3 4 5 6 7 8 9 10 (Unberable)

History of Treatment

Primary Care Physician _____ **Facility** _____ **Phone** _____

Have you seen a Chiropractor before? □ Yes □ No **If yes, when was your last visit?** _____

Have you seen another doctor for these symptoms? If yes, who? _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition

_____

List any surgeries or hospitalizations you have had complete with the month and year for each _____

_____

List any allergies _____

Family History (list all major diseases such as cancer, diabetes, heart problems, etc and the relation to you and the individual)

_____

_____

Do you smoke? □ Yes □ No **If yes, how many packs per day?** _____ **Are you pregnant?** □ Yes □ No

Description of Condition

Using the key below, mark on the body diagram where you are experiencing the following symptoms:

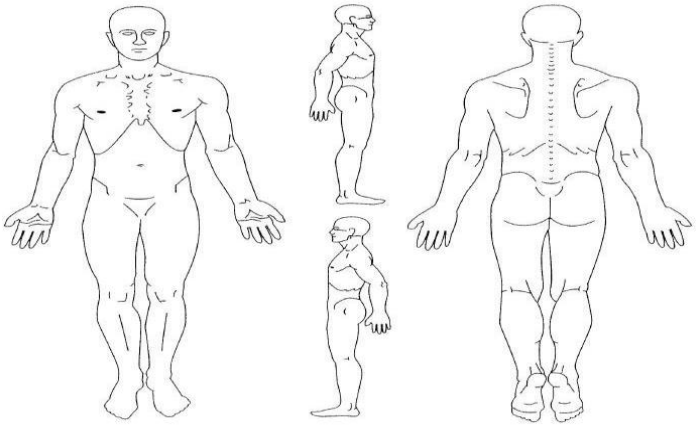
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

Cardiovascular	Past	Present		**Respiratory**	Past	Present		**Allergic/Immunologic**	Past	Present
Poor Circulation				Asthma				Hives		
Hypertension				Tuberculosis				Immune Disorder		
Aortic Aneurism				Short Breath				HIV/AIDS		
Heart Disease				Emphysema				Allergy Shots		
Heart Attack				Cold/Flu				Cortisone Use		
Chest Pain				Cough						
High Cholesterol				Wheezing						
Pace Maker								**Ear, Nose and Throat**	Past	Present
Jaw Pain /TMJ				**Eyes**	Past	Present		Difficulty Swallowing		
Irregular Heartbeat				Glaucoma				Dizziness		
Swelling of legs				Double Vision				Hearing Loss		
				Blurred Vision				Sore Throat		
Genitourinary	Past	Present						Nosebleeds		
Kidney Disease				**Psychiatric**	Past	Present		Bleeding Gums		
Burning Urination				Depression				Sinus Infections		
Frequent Urination				Anxiety						
Blood in Urine				Stress				**Gastrointestinal**	Past	Present
Kidney Stones								Gall Bladder Problems		
Lower Side Pain				**Endocrine**	Past	Present		Bowel Problems		
				Thyroid				Constipation		
Neurologic	Past	Present		Diabetes				Liver Problems		
Stroke				Hair Loss				Ulcers		
Seizures				Menopausal				Diarrhea		
Head Injury				Menstrual				Nausea/Vomiting		
Brain Aneurysm								Bloody Stools		
Numbness				**Hematologic**	Past	Present		Poor Appetite		
Severe Headaches				Hepatitis						
Pinched Nerves				Blood Clots				**Musculoskeletal**	Past	Present
Parkinson's				Cancer				Gout		
Carpal Tunnel				Bruising				Arthritis		
Vertigo				Bleeding				Joint Stiffness		
				Fever, Chills				Muscle Weakness		
Constitutional	Past	Present		Sweating				Osteoporosis		
Difficulty Sleeping								Broken Bones		
Weight Loss/Gain								Joints Replaced		