

New Patient Intake Form

Date: _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____-_____ Work Phone (____) _____-_____

Cell Phone: (____) _____-_____ Email _____

Date of Birth ____/____/____ Sex: Male Female

Employment Status: Employed Retired FT Student PT Student Other _____

Occupation: _____

Emergency Contact:

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____-_____ Cell Phone (____) _____-_____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

- Arthritis
- Hypertension
- Other _____
- Cancer
- Psychiatric Illness
- Diabetes
- Skin Disorder
- Heart Disease
- Stroke

Surgeries: (Circle all that apply to you)

- Appendectomy
- Joint Replacement
- Brain
- Carpal Tunnel
- Other _____
- Cardiovascular procedure
- Prostate
- Shoulder
- Gastro-intestinal
- Cervical spine
- Lumbar spine
- Thoracic spine
- Uro-genital
- Hysterectomy
- Gall Bladder
- Knee
- Hernia

Allergies: (Circle all that apply to you)

- Eggs
- Soy
- Fish and Shellfish
- Sulfites
- Milk or Lactose
- Wheat/Glutens
- Peanuts
- Other _____

Social History: (Circle all that apply to you)

- Caffeine use: occasional often never
- Drink Alcohol: occasional often never
- Exercise: occasional often never
- Chew Tobacco: occasional often never
- Cigarettes: <1 pack/day >1 pack/day never
- Wear Seat Belts: occasional always never

Patient Name _____ Date _____

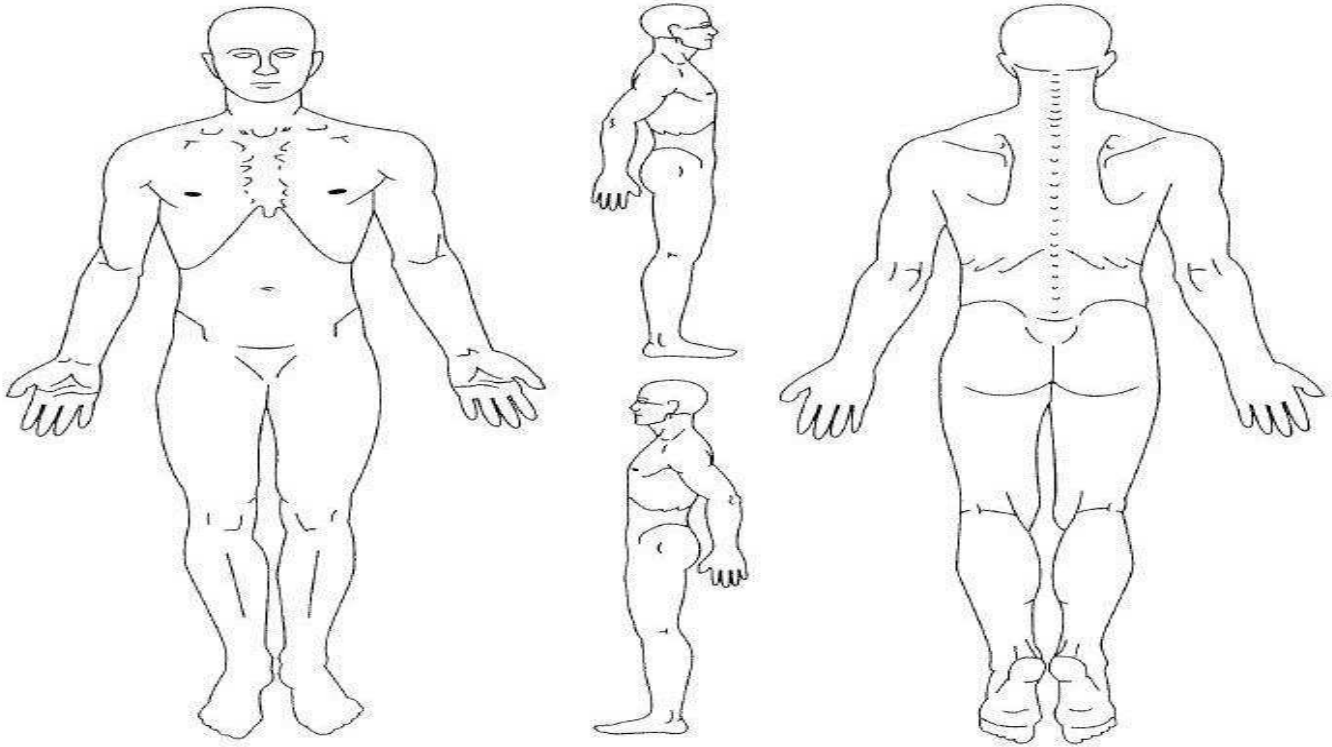
Please list all current medications being taken _____

Female patients: Are you pregnant? Yes _____ No _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache

On a scale of 1-10 (with 10 being high), place the number you would associate with your pain next to each area of concern:



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

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
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What describes the nature of your symptoms?

<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull ache	<input type="checkbox"/> Numb	<input type="checkbox"/> Shooting
<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Other _____

How are your symptoms changing?

<input type="checkbox"/> Getting better	<input type="checkbox"/> Not changing	<input type="checkbox"/> Getting worse
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Patient Name _____

Date _____

Payment/Insurance Information:

Who is responsible for your bill? Self (cash/credit/check/health account) Health Insurance Worker's Comp
 Auto Insur. Medicare Other _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date of accident: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date _____

Contacting Patients:

Dr. Whittington and members of the staff may need to use your name, address or phone number to contact you about appointment reminders, information about treatment, e-mail notices about special events in the office, or other health-related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your machine or with the person answering the phone. By signing below, you are giving us authorization to contact you with these reminders and information.

Signature of Patient or Representative

Date