Whittington Chiropractic 801 Fairview Rd, Ste. 6 Asheville, NC 28803

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

Surgeries: (Circle all that apply to you)

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

Allergies: (Circle all that apply to you)

☐ Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
☐ Soy	Sulfites ☐	Wheat/Glutens ☐	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** _____

Family History: (Check all that apply)

Arthritis:	Parent	Sibling	Cancer: □	Parent	Sibling
Diabetes:	Parent	Sibling	Heart Disease:	Parent	Sibling
Hypertension:	Parent	Sibling	Stroke:	Parent	Sibling
Thyroid:	Parent	Sibling	Other: _____		

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
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				**Ear, Nose and Throat**			
Pace Maker								Difficulty Swallowing			
Jaw Pain				**Eyes**				Dizziness			
Irregular Heartbeat				Glaucoma				Hearing Loss			
Swelling of legs				Double Vision				Sore Throat			
				Blurred Vision				Nosebleeds			
Genitourinary								Bleeding Gums			
Kidney Disease				**Psychiatric**				Sinus Infections			
Burning Urination				Depression							
Frequent Urination				Anxiety							
Blood in Urine				Stress							
Kidney Stones								**Gastrointestinal**			
Lower Side Pain				**Endocrine**							
				Thyroid				Gall Bladder Problems			
Neurologic				Diabetes				Bowel Problems			
Stroke				Hair Loss				Constipation			
Seizures				Menopausal				Liver Problems			
Head Injury				Menstrual				Ulcers			
Brain Aneurysm								Diarrhea			
Numbness				**Hematologic**				Nausea/Vomiting			
Headaches				Hepatitis				Bloody Stools			
Pinched Nerves				Blood Clots				Poor Appetite			
Parkinson's				Cancer							
Carpal Tunnel				Bruising				**Musculoskeletal**			
Vertigo				Bleeding							
				Fever, Chills				Gout			
Constitutional				Sweating				Arthritis			
Weight Loss/Gain								Joint Stiffness			
Low Energy Level								Muscle Weakness			
Difficulty Sleeping								Osteoporosis			
								Broken Bones			
								Joints Replaced			

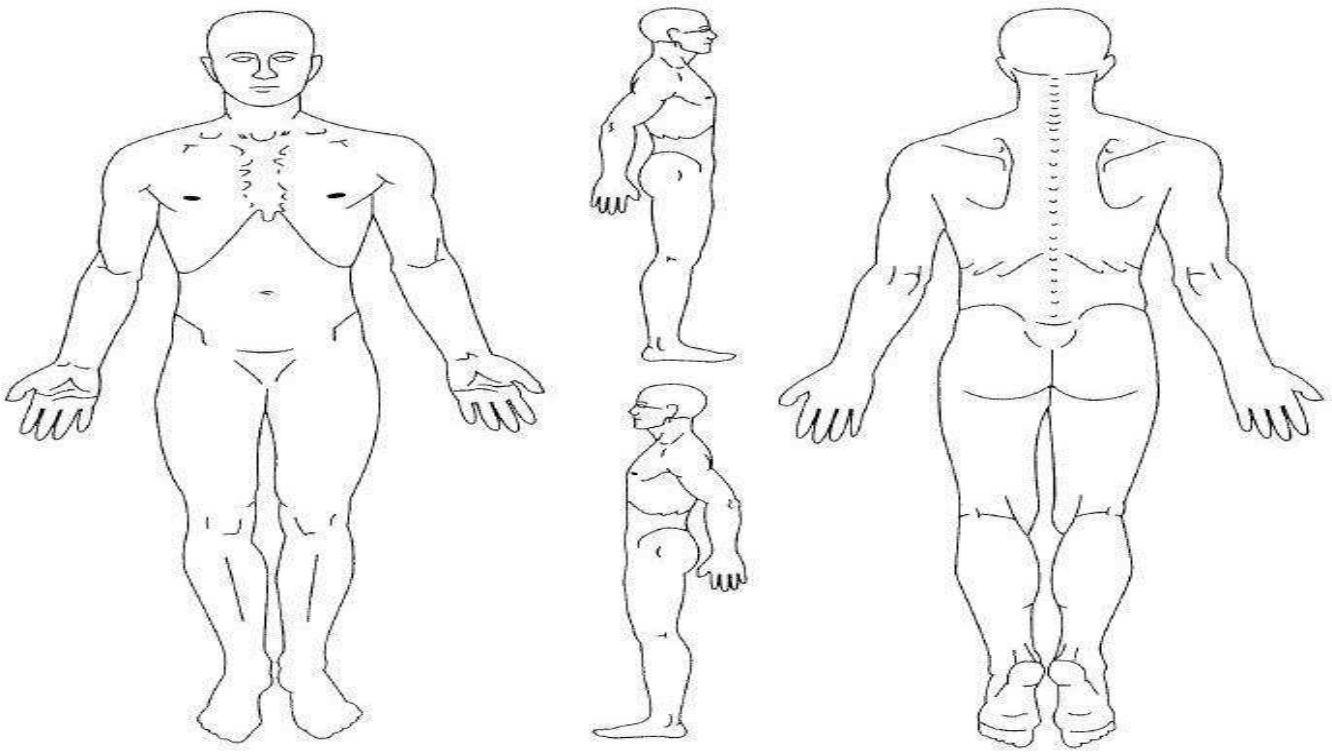
Patient Name_____ **Date**_____

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

What describes the nature of your symptoms?

☐ Sharp	Dull ache	Numb	Shooting
☐ Burning	Tingling	Stabbing	Other _____

How are your symptoms changing?

☐ Getting better	Not changing	Getting worse

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