Patient Confidential Health Record—Intake Form

Please Take A Moment To Fill Out The Following:

Name _____ Social Security # _____ Today's Date _____

Gender: _____ Age _____ DOB _____Email _____

Address _____ City _____ State _____ Zip ____

Mobile # _____ Home # _____ Work # _____

Occupation _____ Employer _____ Referred By _____

Marital Status: Married Single Widowed Divorced Partnered Spouse's Name _____

Emergency Contact Name & Relationship_____ Emergency Contact Number _____

What is your chief complaint or reason for your visit?

When did it start?

How did this begin?

What is your pain level and frequency?

Is there a time of day that your symptoms are worse?

Rate your pain, where 0 is no pain and 10 is worst pain:

Can you describe the quality of pain (i.e., aching, burning, dull, sharp, etc.):

What makes symptoms better?

What makes symptoms worse?

Do you have any additional symptoms?

Have you been to a chiropractor before? Y / N If yes, who was your doctor and when did you see him/her?

Patient Signature:_____Dat___/____/_____

(Guardian must sign for all patients 17 years old or younger)

Patient Confidential Health Record—Intake Form

List the name and address of your primary care physician & any specialist you have seen for this Complaint/Treatment Given/Result of Treatment:

Describe any past history of the same or similar complaint:

List any surgeries you have had (include date, type of surgery and outcome):

List chronic or past health conditions:

List of medications:

Have you had an X-Ray or MRI or other tests for your current condition? What tests and when?

Are you currently working?

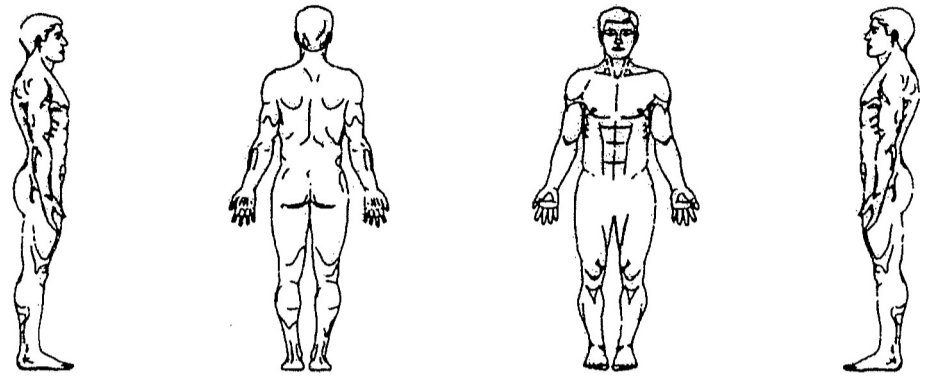
If yes, your occupation:

Employer:

Exercise (type and frequency):

List hobbies, recreational sports, and activities that you enjoy doing:

Pain Diagram: Please circle the area(s) where you have pain or other symptoms. Include symptoms of pain, numbness and/or tingling.



Patient Signature:_____Date:___/____/_____

(Guardian must sign for all patients 17 years old or younger)

Patient Confidential Health Record—Intake Form

Please check the boxes of the conditions that apply to your family.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Age of Onset	Description
Arthritis (type?)	__	__	__	__	__	__	__	__	__	_____
Allergies	__	__	__	__	__	__	__	__	__	_____
Cancer (type?)	__	__	__	__	__	__	__	__	__	_____
Diabetes	__	__	__	__	__	__	__	__	__	_____
Epilepsy	__	__	__	__	__	__	__	__	__	_____
Heart Problems	__	__	__	__	__	__	__	__	__	_____
Lung Problems	__	__	__	__	__	__	__	__	__	_____
Mental Disease	__	__	__	__	__	__	__	__	__	_____
High Blood Pressure	__	__	__	__	__	__	__	__	__	_____
Other	__	__	__	__	__	__	__	__	__	_____

Please complete the following information regarding your lifestyle.

Tobacco: __ packs/day for ___ years Alcohol: ____ glasses/day Coffee/Tea/Caffeinated Soft Drinks: _____ glasses/day

Recreational Drugs: _____ Exercise: ____ hours/week Water: _____glasses/day average

Sleep Quality: _____ hrs. sleep/night My Sleep Is: ___ Restful ___Restless ___Wake up often ___ Hard to get sleep

Present Weight: _____lbs. Present Height: _____ I have had recent ABNORMAL: ___Weight Gain ___Weight Loss

Do you have a permanent disability rating? Yes/No Location: _____ Rating: ____% Date Received: _____

General Understandings:

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I, the undersigned, consent to chiropractic care in this office.

I clearly understand and agree that I am responsible for payment of any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Please note that patients are responsible for seeking reimbursement from their group or individual insurance and are responsible for paying the full amount for services at the time of visit. For our Medicare patients, full payment is due at time of service. We will submit the appropriate forms to Medicare for you. Medicare usually will reimburse you for a small portion of the chiropractic services you receive.

Regarding the national Health Information Portability and Accountability Act (HIPAA): All information that is obtained from you by this office is protected and kept confidential in accordance with HIPAA mandated standards. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced. Our HIPAA policy is not a contract, authorization, release, or form of consent. A copy of our HWAA policies is presented to you at the time of your initial evaluation. You may request a paper or electronic version of these policies at any time. The signature below acknowledges that you have read and been offered a copy of this office's Notice of Privacy Practices.

Patient Signature:_____Date: _____

(Guardian must sign for all patients 17 years old or younger)