210 FAMILY CHIROPRACTIC CENTER

New Patient Intake Form Today's Date:_____

Title: (Circle one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Age: _____ Sex: Male Female

Social Security Number: _____-_____-_____ Marital Status: □ Single □ Married □ Other

How did you hear about our office? _____

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data _____

Employer _____

Your Occupation _____

Spouse Data _____

First Name _____ Middle Initial ____ Last Name _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact _____

Contact Name _____ Relationship to Patient _____

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

What is the reason for this visit? _____

When did your symptoms begin? _____

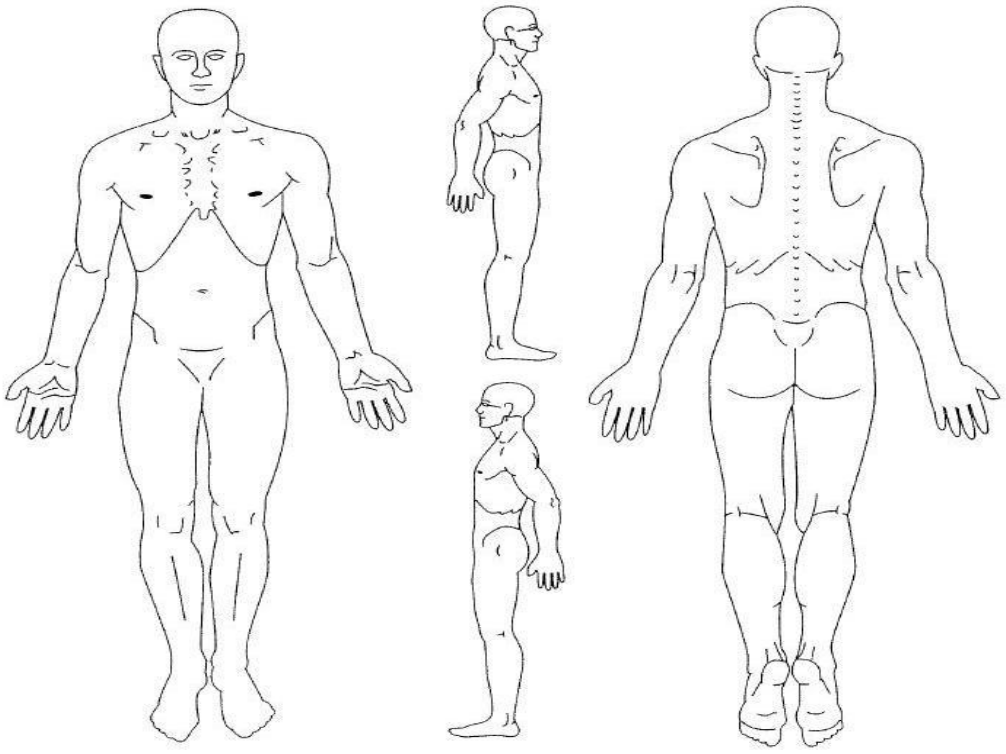
Are they a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

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

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No

If Yes, please list:_____

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)

What describes the nature of your symptoms?

□ Sharp □ Ache □ Numb □ Shooting
□ Burning □ Tingling □ Throbbing □ Other _____

How are your symptoms changing? Getting better Not changing □ Getting worse

Medical Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Other _____	Fibromyalgia	Asthma	Osteoporosis

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
□Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

□ Mold	□ Seasonal	□ Milk or Lactose	□ Animal
□ Chemical _____	Sulfites	□ Wheat/Glutens	□ Other _____

Please list all current medications being taken: _____

_____

Are You Pregnant? (Circle) **Yes No** **Due Date:**_____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Drink Water:	□ <64 oz/day	□>64 oz/day	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Sleep:	□<8 hours/night	□ >=8 hours/night	Insomnia □

Other _____

Family History: (Circle 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 _____

Occupational Activities: (Circle one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Homemaker

Review of Systems – (Check box if you have had trouble with any of the following)

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

210 FAMILY CHIROPRACTIC CENTER

CHIROPRACTIC CARE - INFORMED CONSENT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and headache. Most adverse events associated with spinal manipulation are benign and self-limiting. The incidence of severe complications following chiropractic care and manipulation is extremely low. The best evidence suggests that chiropractic care is a useful therapy for subjects with neck or low-back pain for which the risks of serious adverse events should be considered negligible (JMPT, 2008 Jul-Aug;31(6):461-4).

AUTHORIZATION AND FINANCIAL RESPONSIBILITY:

I certify that I have read and understand the above information to the best of my knowledge. My questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including diagnosis, records, treatment and examination rendered to me or my child to third party payers and/or health practitioners including but not limited to my primary care physician. I authorize use of this form as consent for Essence of Wellness Chiropractic Center to obtain medical records from any physician or healthcare facility for which I have been treated by/at. I authorize and request my insurance company to directly pay the chiropractor for group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services rendered. I understand I am responsible for services provided by the doctors or therapists, even though, my insurance company may determine them to be not medically necessary, a non-covered service or an out of network service. Any unpaid balance not paid by insurance is the patient's responsibility. I agree to be responsible for payment of all services rendered to me or my dependents. Payment for services are due at the time services are rendered unless other arrangements have been approved in advance by our staff. If you have a co-pay, we will accept that until we have received notice or payment from your insurance company. Your claims will be filed by us as a courtesy. I understand that there will be an additional fee of $25.00 for any non-sufficient funds check resented to our office for payment upon my account. I fully understand this agreement between this office and myself. My signature below provides my consent to chiropractic care and authorization that I am responsible for the balance of my account for any professional services rendered.

X_____ ___/___/___
Patient Signature Date

X_____ ___/___/___
Signature of Parent or Guardian (If a minor) Date