New Patient Intake Form

Welcome! Chiropractic and Functional Medicine work best when the Doctor has a complete understanding of your history. Please fill out this intake form as completely as you can.

Name _____ Date_____

Address _____ City _____ Zip_____

Email _____ Phone (cell/home or work) _____ / _____

Gender (M/F/T*)_____ Date of Birth_____ Social Security # _____

Occupation _____ Employer _____

Referred By _____ Primary Care Physician _____

Please check applicable option: ❑ Married/Partnered ❑ Single ❑ Children (number/ages _____)

IF MARRIED:

Spouse's Name _____ Employer _____ Work Phone _____

IF CHILD:

Parent's Name _____ Employer _____ Work Phone _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Name of Insured Person _____ Insured's Date of Birth _____

Name of Insurance Company/Insurance ID # _____ /_____

Are you interested in receiving email notification of classes, lectures and health information? ❑ YES ❑ NO

PRESENT COMPLAINTS

Primary Complaint _____

_____

_____

Other Most Important Health Problems (please list in order of importance)

1. _____

_____

2. _____

_____

3. _____

_____

DISCOMFORT RATING SCALE – Please circle the number indicating your level of discomfort

1. What is your discomfort right now? 0 1 2 3 4 5 6 7 8 9 10

2. What is your typical average discomfort? 0 1 2 3 4 5 6 7 8 9 10

3. What is your discomfort at its worst? 0 1 2 3 4 5 6 7 8 9 10

REGARDING YOUR PRIMARY COMPLAINT

1. How often do you experience it? ❑ Constantly (100%) ❑ Frequently (75%) ❑ Intermittently (50%) ❑ Occasionally (25%)

2. Since your problem began, is it ❑ Increasing ❑ Decreasing ❑ Not Changing

3. When did your problem begin? (specific date, if possible) _____

4. Did your problem begin ❑ Immediately after an accident ❑ Decreasing ❑ Not Changing

5. Describe how your problem began _____

_____

6. Have you lost any days of work? ❑ No ❑ Yes Dates _____

7. What treatment have you received for this present condition? ❑ Chiropractic ❑ Medication ❑ Surgery ❑ Acupuncture Therapy from a PT ❑ Massage ❑ Nutritional Medicine ❑ Naturopathy ❑ Osteopathy ❑ Other _____

8. What makes your problem better? ❑ Nothing ❑ Lying Down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Inactivity ❑ Nutritional Medicine ❑ Medication ❑ Other _____

9. What makes your problem worse? ❑ Nothing ❑ Lying Down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Inactivity ❑ Nutritional Medicine ❑ Medication ❑ Other _____

10. How would you describe your general stress level ❑ None ❑ Minimal ❑ Moderate ❑ High

11. List any relatives that have had similar problems _____

12. Are your complaints affecting your ability to work or otherwise be active?

❑ No Effect ❑ Some Physical Restrictions (able to perform light duty work and household tasks)

❑ Need Limited Assistance ❑ Need Assistance Often ❑ Significant Inability to Function Without Assistance

13. Have you recently experienced weight gain/loss of more than 10 pounds? ❑ YES ❑ NO

14. Describe your physical activity at work

❑ Sedentary 50% or more ❑ Light Manual Labor ❑ Manual Labor ❑ Heavy Manual Labor

15. In your opinion, how physically fit are you right now? ❑ Unfit ❑ Below Average ❑ Average ❑ Above Average ❑ Very Fit

16. How long has it been since you really felt good? _____

17. Have you been treated for any health condition by a health practitioner in the last year? ❑ No ❑ Yes

If Yes, please explain _____

18. Have you or any relative previously received Chiropractic, Functional Medicine and/or alternative treatment? ❑ No ❑ Yes

If Yes, please explain _____

19. Approximate dates of any operations, diseases, serious illnesses, broken bones, accidents, hospitalizations

_____

20. List all drugs or medications that you have used recently, including aspirin, sleeping pills, birth control, etc.

_____

Benefits and/or side effects _____

21. How stressed are you? (0 = Calm, 10 = Over the top) 0 1 2 3 4 5 6 7 8 9 10

22. Sleep habits and history Typical Bedtime _____ Typical Wake Up Time _____ Average hours sleep ____

Quality of sleep _____ Difficulty falling/staying asleep _____ Wake refreshed? ❑ Yes ❑ No

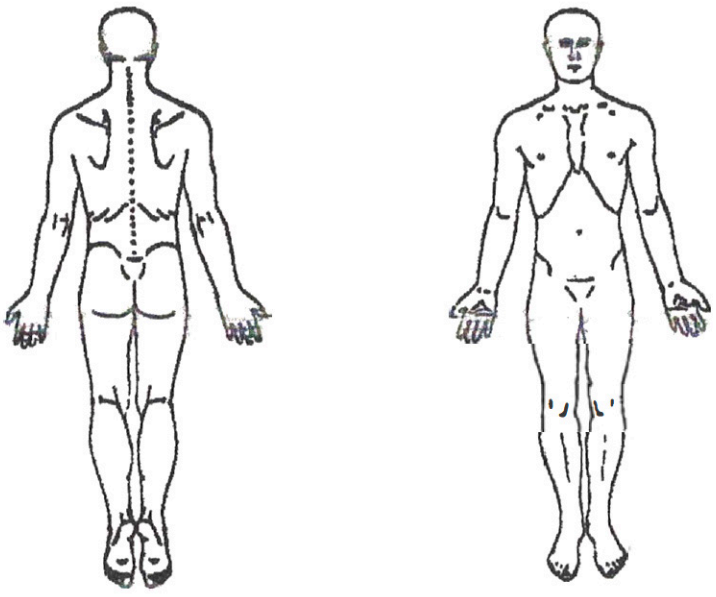
23. What are your current health and fitness goals? (palliative, preventative, optimal health/function) _____

_____

24. Mark the areas of your body where you feel the described sensations, if applicable.

Include all affected areas, mark areas of radiation, use the appropriate symbols.

Aching	X
Burning	/
Cramping	Z
Tingling	=
Sharp	#
Stabbing	O
Numbness	+
Dull	?
Throbbing	T
Shooting	S



RELEASE AND ASSIGNMENT

Our office composed the following financial policy to clarify our billing charges and procedures in the hope of avoiding any misunderstandings or unnecessary upsets in the future regarding unanticipated charges. Please read this notice and sign at the bottom. If you need clarification, please speak to the office manager.

I understand that although I have assigned insurance benefits to this office, it is probable that my insurance coverage will be less than the amount billed. Unless my doctor has a contractual agreement with my insurance company that states otherwise, I acknowledge that I am responsible for any charges refused or discounted by my insurance company and that it is my responsibility to pay any remaining balance of my bill. Deductibles and copays are paid at the time of service. If we are considered "out of network" with my insurance, my insurance company will reimburse me directly and I am responsible for paying all the changes at the time of service.

Except as to the above, I understand that this office does not bill the patient but, rather, expects payment of my estimated portion on the day treatment is rendered.

Signature _____ Date _____

Consent to treat minor _____ Date _____