

# New Patient Intake Form

## Patient Data

Date

**Title:** (Check one)    Mr.    Mrs.    Ms.    Miss    Dr.    Other \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Address Line 1** \_\_\_\_\_

**Address Line 2** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      **Carrier** \_\_\_\_\_

**Email** \_\_\_\_\_      **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Sex:**    Male       Female      **Marital Status:**    Single    Married   Widowed

**Employment Status:**    Employed    Unemployed    FT Student    PT Student    Other\_\_\_\_\_

## Spouse Data

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Employer Data

**Name** \_\_\_\_\_

**Your Occupation** \_\_\_\_\_      **Your Job Description** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

## Emergency Contact

**Contact Name** \_\_\_\_\_      **Relationship to Patient** \_\_\_\_\_

**Contact Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Doctor's Signature** \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

**Medical Conditions:** (Check all that apply to you)

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Other _____  |  |  |  |

**Surgeries:** (Check all that apply to you)

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate                 | <input type="checkbox"/> Lumbar spine   | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain             | <input type="checkbox"/> Shoulder                 | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee         |
| <input type="checkbox"/> Carpal Tunnel     | <input type="checkbox"/> Gastro-intestinal        | <input type="checkbox"/> Uro-genital    | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Other _____       |   |   |                                       |

**Allergies:** (Check all that apply to you)

- |                               |   |  |                                      |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts     |
| <input type="checkbox"/> Soy  | <input type="checkbox"/> Sulfites           | <input type="checkbox"/> Wheat/Glutens   | <input type="checkbox"/> Other _____ |

**Social History:** (Check all that apply to you)

- |                  |                                      |                                      |                                |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use:    | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Drink Alcohol:   | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Exercise:        | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Chew Tobacco:    | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Cigarettes:      | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional  | <input type="checkbox"/> always      | <input type="checkbox"/> never |
| Other _____      |                                      |                                      |                                |

**Family History:** (Check all that apply)

- |               |                                 |                                  |
|---------------|---------------------------------|----------------------------------|
| Arthritis:    | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer:       | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes:     | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension  | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke        | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid       | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____   |                                 |                                  |

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

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Administration           | <input type="checkbox"/> Business Owner      | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare   | <input type="checkbox"/> Construction       | <input type="checkbox"/> Health Care   |
| <input type="checkbox"/> Food Service Industry    | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing      | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor       | <input type="checkbox"/> Light Manual Labor  | <input type="checkbox"/> Executive/Legal    | <input type="checkbox"/> Housekeeper   |
| <input type="checkbox"/> Other _____              |  |   |  |

Doctor's Signature \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

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

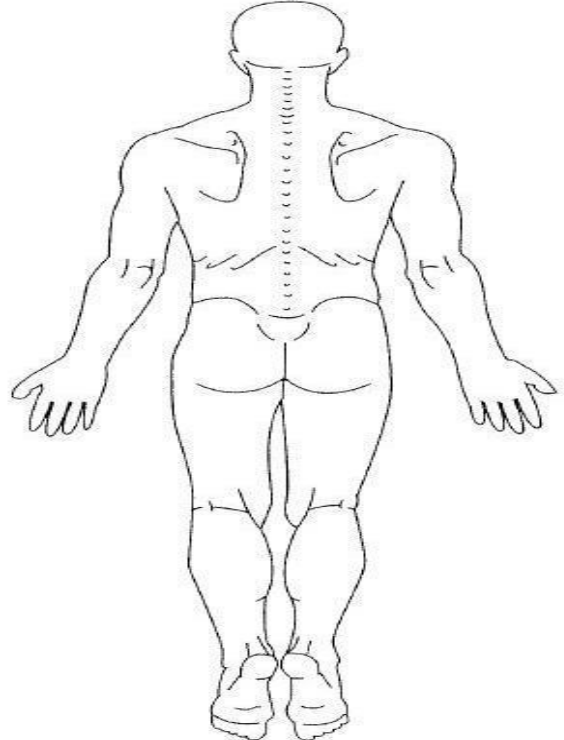
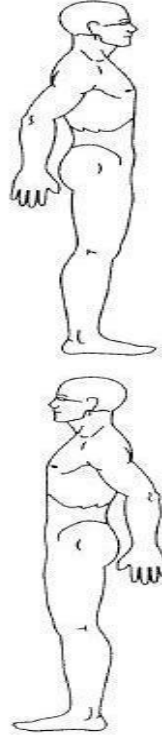
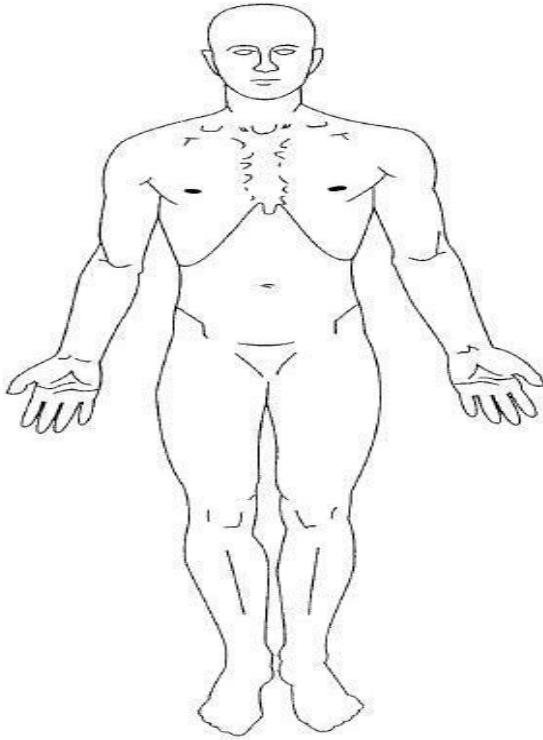
**N=Numbness**

**B=Burning**

**S=Stabbing**

**T=Tingling**

**A=Dull Ache**



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

\_\_\_\_\_  
\_\_\_\_\_

When did your symptoms begin?      **Month** \_\_\_\_\_      **Day** \_\_\_\_\_      **Year** \_\_\_\_\_

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

How did your symptoms begin? \_\_\_\_\_

**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

Dull ache

Numb

Shooting

Burning

Tingling

Stabbing

Other \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Payment/Insurance Information:**

Who is responsible for your bill?    Self    Spouse    Worker's Comp  
 Auto Insurance

**Worker's Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?    Yes    No   Date: \_\_\_\_/\_\_\_\_/\_\_\_\_   Time: \_\_\_\_\_ am / pm

**Social Media Release**

We love to celebrate your success! Please indicate whether you are Social Media Friendly:

- Yes, Integrative Chiropractic & Wellness may use my name and image on Social Media**
- No, I prefer to remain off the internet.**

**Cancellation Policy**

Our office has a 24-hour cancellation policy. We reserve the right to charge a \$50 fee for appointments cancelled within 24 hours. We also reserve the right to charge a \$50 fee for missed appointments.

Initials \_\_\_\_\_

**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 \_\_\_\_\_

**SIGNATURE OF PHYSICIAN:** \_\_\_\_\_ **Date:** \_\_\_\_\_