

New Patient Intake Form

Name: _____ Date _____

Address: _____ City, State, Zip: _____

May we leave a phone message to confirm your appointment? Yes No

Phone: Home () _____ Work () _____ Cell () _____

eMail: _____

Date of birth: _____ Age _____ Sex: F M Who referred you to our office? _____

Married Single Senior (over 65) Full time student Minor (under 18) Height _____ Weight _____

Chief complaint (reason why you are here): _____

Current medications/drugs/hormones you take (either prescription or over-the-counter): _____

Are you currently under the care of another doctor? Yes No If yes, name of doctor/s and date/s of last visit: _____

Nutritional supplements you take: _____

If this visit is for CHIROPRACTIC CARE under your insurance plan, please provide your card and complete the following:

(The Nutrition programs are NOT covered by insurance.)

Health Plan: _____ Subscriber name _____

Subscriber date of birth _____ Spouse name: _____ Spouse employer: _____

Primary care Physician (PCP): _____ PCP Phone: _____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered. I agree to notify this doctor immediately whenever I have any changes in my health condition or health plan coverage in the future. If coverage is managed under Plans including but not limited to ASH or ACN, I understand that my chiropractor or a clinical peer employed by my plan may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or such clinical peers to contact my physician, if necessary.

PAST HEALTH HISTORY

Surgery: Appendectomy Tonsillectomy Gallbladder Hernia Back Surgery Date/s: _____

Hysterectomy Broken bones Cosmetic surgery/implants Other/Date: _____

Accidents or falls/dates: _____ Other hospitalizations/dates: _____

	Never	<1	1-2	2-3	3-4	5+	Please check all that apply: or <input type="checkbox"/> None apply	
Tobacco: Packs/ day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Recent infection	<input type="checkbox"/> Endometriosis
Caffeinated drinks/ day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Recent fever	<input type="checkbox"/> Visual disturbances
Water (8 oz)/ day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Difficult urination/ bowel movement
Sweets: per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Aortic aneurism	<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines
Fruits/veg: per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Excessive urination
Meat/fish: per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke (date) _____	<input type="checkbox"/> Arthritis (where?) _____
Alcohol Drinks/ week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> History of mid/low back pain
Exercise: times / week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> History of neck pain
Fast food: times/ week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cancer/tumor	<input type="checkbox"/> Numbness (where?) _____
History of alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Anemia
History of tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					Diabetes: <input type="checkbox"/> adult <input type="checkbox"/> juvenile	<input type="checkbox"/> Anorexia Nervosa
							<input type="checkbox"/> Abnormal weight gain	<input type="checkbox"/> Binge Eating disorder
							<input type="checkbox"/> Abnormal weight loss	<input type="checkbox"/> Bulimia Nervosa
							<input type="checkbox"/> Corticosteroid use	<input type="checkbox"/> Other Eating disorders
							<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Food allergies/sensitivities
							<input type="checkbox"/> Birth control meds/patch	<input type="checkbox"/> Fibromyalgia
							<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Chronic fatigue
							<input type="checkbox"/> Pregnancy, # of births	<input type="checkbox"/> Mental/emotional challenges/disorders
								<input type="checkbox"/> Chemical/Alcohol Dependency

Name: _____

Do you have any scars (even small ones or old ones from a cut or burn): No Yes If yes, where? _____

Family Health History (parents, grandparents, brothers, sisters): Heart disease Cancer Stroke Diabetes High blood pressure

What are your primary concerns?		
Low energy Low stamina Overweight Underweight Difficulty sleeping Difficulty waking Stress Digestive problems	Mood swings Depression Poor concentration/memory Irritable, impatient Fatigue Headaches	Back pain Neck pain Other _____ _____ Pain (where?) _____

What are your goals?		
Decrease body fat Increase stamina Build muscle Improve physical performance Improved sense of well being	Improve nutrition Develop exercise regimen Lower stress Improve mental performance Relieve pain	Lose weight (Ideal weight: _____) Gain weight (Ideal weight: _____) Desire to maintain current weight Other _____

AGREEMENT CONCERNING SCOPE OF CARE

You have come to this office with the desire to improve your general health and well being by means of natural techniques including, but not limited to chiropractic care, dietary, nutritional and/or exercise programs, and life skill recommendations. The benefits of these tools are relative to your level of participation. You may or may not at the same time be under the care of another physician or health care provider for primary care or for a specific ailment. It is important to understand clearly the scope and extent of the services which we expect to render in your case.

Health care is a shared responsibility that requires trust and open communication. In this regard:

You hereby give permission to your Provider to be direct and forthright in making health care recommendations.

You agree to be responsible for having your health program work for you. That is, you will participate to the best of your ability in following recommendations for your health care, and advise your Provider of any challenges or concerns that arise, as well as what is working and what is not working in your health program.

In this regard:

1. Your Provider will determine if she/he is trained to address your specific issues and concerns
2. If not, you will be referred to your primary care physician (if applicable) and/or other appropriate professionals, with the mutual understanding that you always have a choice in your selection of health care options.
3. If you express that to your Provider that your health needs are not being met by the programs or information offered, you will be provided with referrals to appropriate professionals as outlined above.

The health of our patients is our primary concern, and your appointment time is reserved exclusively for you. If a session must be rescheduled, you agree to provide 24-hours notice to this office, and your appointment will be rescheduled according to availability. If two or more scheduled appointments are missed without providing the required notice, you may be charged up to the full cost of the missed appointment.

You agree to be honest and complete in providing relevant personal information. It is essential for this Provider to be aware of past and present events, addictions, conditions, and/or medications that may directly influence your life, health and well being now, such as a 12-step program, therapy, or learning disability. Please specify any relevant information in the space provided below:

It is not within the scope of this practice to prescribe medications or their dosages; however, they may be appropriate in certain circumstances, and you may be referred for medical evaluation and/or consultation to determine the relevance to your condition. Any change in your current medication that you consider is first to be discussed with the prescribing physician or appropriate medical health provider. Serious side effects can occur if you discontinue, reduce or increase the recommended dosage without supervision of a qualified medical health provider.

I have read and understand the above. Under the conditions indicated, I hereby place myself under your care for such consultation, recommendation of nutritional supplementation, therapies and resources as may appear to be indicated in your judgment.

SIGNATURE

Date

Signature of Parent or Guardian if Minor

Date