

# NEW PATIENT INTAKE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

We use text messaging for appointment reminders. Who is your cell phone company? \_\_\_\_\_

Email Address: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_


Employer Name and Address: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Have you seen a Chiropractor before? Yes No If yes, when? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## YOUR HEALTH SUMMARY

Please  check all symptoms you have ever had, even if they do not seem related to your current problem.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck stiff               | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Cold sweats              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Problem urinating      | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers          |

List any medications you are taking \_\_\_\_\_

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_