Rivergate Chiropractic
1994 Gallatin Pike N.
Suite 206
Madison, TN 37115
615-859-6677

New Patient Intake Form

Patient Information

Personal Information

First Name: _____

Middle Name: _____

Last Name: _____

Gender: O Female O Male

Date of Birth: _____

Social Security #: _____

Height: _____ Feet _____ Inches

Weight: _____

Marital Status: _____

Spouse's Name: _____

Number of Children: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Contact Information

Email: _____
(We will not share your email with any third party. We will only use your email to contact you in relation to your care in our practice.)

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Address Line 1: _____

Address Line 2: _____

City: _____

State/Province/Region: _____ Zip Code: _____

Employment Information

Regular Work Status: _____

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Occupation: _____

Supervisor Name: _____ Supervisor Phone / Extension: _____

Physical Work Duties: _____

What is the purpose of your visit?
Wellness Complaint Injury Other

Current Symptoms

Where did the injury occur?
Automobile Work 3rd Party Premises Other

Date of Injury:

Please Describe how the injury, pain, or discomfort originated:

Please describe your pain/discomfort:

Select frequency you experience pain from this condition:
Always Hourly Daily Occasionally

Does this condition interfere with any of your daily activities or routines?
No Yes

Has this condition affected your quality of sleep or ability to sleep?
No Yes

Has this condition affected your appetite?
No Yes

If Yes, Explain:

Have you missed any work due to this injury?
No Yes

If yes: Unable to work from date: _____
Day you have or will return to work: _____

Have you reduced or limited your work hours because of this condition?
No Yes

If Yes, Explain:

Is the pain/discomfort worse at certain times of the day?
No Yes

If Yes, Explain:

Does the weather affect your pain/discomfort?
No Yes

If Yes, Explain:

List anything that aggravates your condition:

List anything that relieves or improves your condition:

Have you received professional treatment for this condition?
No Yes If Yes, Explain:

Have you had X-rays taken for this condition?
No Yes

If Yes, Where?

Pain level Rating - Scale 1 to 10 (Where 1 is least pain and 10 is maximum pain)
At its best: _____ At its Worst: _____ Current Level: _____

Have you ever had this same condition?
No Yes

If Yes, When?:

List other practitioners seen for this injury/condition:

Insurance & Payment for Care

How do you plan to pay for care?
Personal Insurance Third-Party Insurance No Insurance, Self-Pay

Name of Party Responsible for Payment: _____

Responsible Party Phone: _____

Primary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

Secondary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

If an auto accident, please provide:

Claim #: _____ Insurance Contact Person: ____

Insurance Phone: _____

Attorney's Full Name: _____ Attorney's Phone:

Personal Health History

Family/Primary Physician

Date of Last Physical Exam: _____

Name of Physician Seen: _____ Physician Phone: _____

Physician City: _____ Physician State: _____ Physician Zip: _____

Please list any health conditions that you have been treated for in the last year:
(condition, cause, current/resolved)

Have you had previous chiropractic care?
No Yes

Condition(s) treated:

Date of last chiropractic visit:

Are you pregnant, or have you had any signs of pregnancy? (Female Only)
No Yes

Are you planning to get pregnant in the next 12 months? (Female Only)
No Yes

List current medications:
(name, amounts, frequency, length of use, reason for use)

List current vitamins, minerals, supplements, or herbs:
(name, amounts, frequency, length of use, reason for use)

Personal Incident History:

Broken Bones?
No Yes

If yes:
Did you get professional care/treatment?
No Yes
Briefly Explain:

Had Major Sprains/Strains?
No Yes

If yes:
Did you get professional care/treatment?
No Yes
Briefly Explain:

Been Hospitalized?
No Yes

Briefly Explain:

Had Surgery?
No Yes

Briefly Explain:

Been In Auto Accident?
No Yes

If yes:
Did you get professional care/treatment?
No Yes
Briefly Explain:

Been Struck Unconscious?
No Yes

If yes:
Did you get professional care/treatment?
No Yes
Briefly Explain:

Been Diagnosed with an Eating Disorder?
No Yes

Briefly Explain:

Had a Stroke?
No Yes

Briefly Explain:

Family Health History

Please list diagnosed health conditions and untimely deaths.(condition, relationship to you)
(Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)
(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Social History & Life Choices:

Alcohol
Daily Weekly Occasionally Never

Caffeine Drinks & Products
Daily Weekly Occasionally Never

Diet Food Products
Daily Weekly Occasionally Never

Drugs
Daily Weekly Occasionally Never

Energy Products or Over-the-Counter Stimulants
Daily Weekly Occasionally Never

Exercise
Daily Weekly Occasionally Never

Fresh & Homemade Foods
Daily Weekly Occasionally Never

Preprocessed, Packaged, & Restaurant Food
Daily Weekly Occasionally Never

Soft Drinks
Daily Weekly Occasionally Never

Tobacco
Daily Weekly Occasionally Never

Water
Daily Weekly Occasionally Never

Chiropractic Experience

Who referred you to our office?

Where did you hear about us?… Please select all that apply
Newspaper Sign Yellow Pages Community Event Mailing Other:

Have you been adjusted by a chiropractor before?
Yes No

If yes…
What was the reason for those visits?

Doctor's Name: _____

Approximate date of last visit: _____

Has any member of your family ever seen a wellness chiropractor?
Yes No

Reason for this Visit

Describe the reason for this visit

Please briefly describe, including the impact it has had on your life.
If you're only here for chiropractic wellness services please skip this section.

Wellness Sports Auto Fall Home Injury Job Chronic Discomfort Other

Briefly Explain:

When did this concern begin?

Has this concern:
Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with:
Work Sleep Daily Routine Other Activities

Briefly Explain:

Has this concern occurred before?
Yes No

Briefly Explain:

Have you seen other doctors for this concern?
Yes No

Doctor's Name: _____

Type of Treatment: _____

Results: Good Bad Indifferent

For Women Only

COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A WOMAN OVER 16 YEARS OF AGE.

Are you pregnant?
No Yes

Are you nursing?
No Yes

Are you taking birth control?
No Yes

Do you experience painful periods?
No Yes

Do you have irregular cycles?
No Yes

Do you have breast implants?
No Yes

Do you perform a regular self breast examination?
No Yes

Do you take hormone replacement therapy (HRT)?
No Yes

Do you take oral contraceptives?
No Yes

Estimate the date of your most recent PAP/pelvic exam:

Date of last mammogram?

Date of Last Menstrual Period?

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

I want the Doctor to select the type of care appropriate for my condition.

O **Relief care:** Symptomatic relief of pain or discomfort.
O **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
O **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Were You Aware That...

Doctors of Chiropractic work with the nervous system?
No Yes

The nervous system controls all bodily functions and systems?
No Yes

Chiropractic is the largest natural healing profession in the world?
No Yes

Health Problems & Concerns:

Please select all that you have had or currently have.

- Allergies
- Alcoholism
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Autoimmune Disease
- Back Pain
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Cataracts
- Chest Pain
- CHF (congestive heart disease)
- Cold Extremities
- Constipation
- COPD/emphysema
- Cramps
- CVA (stroke/TIA)
- Dementia/Alzheimer's
- Depression
- Diabetes
- Digestion Problems
- Diagnosed emotional/mental disorders
- Dizziness
- Epilepsy
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Gallbladder disease/stones
- Glaucoma
- Gout
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Menstrual Cycle
- Kidney Infection Kidney Stones
- Liver disease/cirrhosis
- Loss of Memory
- Loss of Balance
- Loss of Smell
- Loss of Taste
- Lung disease
- Macular Degeneration
- Migraines
- Nosebleeds
- Pacemaker
- Parkinson's
- Polio Poor
- Posture
- Prostate Trouble
- Retinal Disease
- Sciatica
- Seizures
- Shortness of Breath
- Sinus Infection
- Sleep Problems/Insomnia
- Skin Sensitivity
- Smoked
- Spinal Curvatures
- Stroke
- Swelling of Ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other

Other:

Have you had any of these Cardiovascular Diseases? Please select all that apply.
Myocardial infarction Hypertension Hypercholesterolemia Bypass surgery

Coronary artery disease

Do you have Diabetes? If so what type?
Type I Type II Juvenile

Do you have any stomach/digestive issues? Please select all that apply.
Ulcers Reflux IBS

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ☐ **I agree with this statement of authorization**

Signature

Name of the Insured: _____
(Please Print)

Parent's / Guardian's
Signature: _____ Date: _____