

NEW PATIENT INTAKE



Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone (____) _____ Cell (____) _____ Work (____) _____

We use text messages for appointment reminders. Who is your cell phone carrier? _____

Email Address: _____ Male _____ Female _____

Birth Date: _____ Age _____ Occupation: _____

Single _____ Married _____ Spouse's Name _____

Family Doctor: _____ Phone: _____

Reason last seen? _____ May we contact your doctor if necessary? Yes No

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

What is your primary complaint? _____

Check all symptoms you have ever had even if they do not seem related to your primary complaint.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> TMJD | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Tension | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins and Needles in Legs |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Numbness in Toes |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Other: _____ | | | |

Please list any medications you are taking: _____

If this is due to an injury or auto accident, what is the date of injury or accident? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your condition worse? _____

What have you tried that has helped your condition? _____

Have you seen a chiropractor in the past? _____ If yes, when? _____

Any past surgeries or hospitalizations? _____

Do you have insurance? Yes No | HSA account? Yes No | Self-pay? Yes No

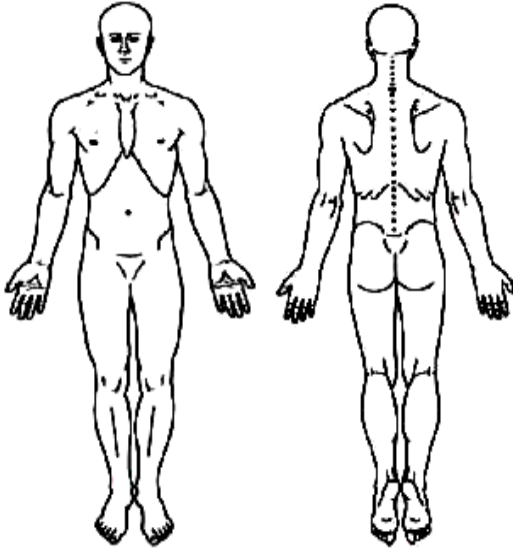
Are you the primary policy holder? Yes No | If 'No' please provide:

Policy holder name : _____ Policy holder date of birth: _____

Patient Name: _____ Date: _____

If you are in pain, please mark the exact location of your pain AND any other details about your pain on the diagram using the abbreviations listed below. If you need to make further descriptions use the 'other' box.

D = dull | S = sharp | B = burning | A – Aching
C = constant | I = Intermittent | St = standing | Si = sitting | Ly = Lying down



Other:

Authorization / Consent / Assignment of Benefits / HIPAA / Pregnancy

I _____ hereby grant permission to receive a chiropractic evaluation including history, posture evaluation, examination and x-rays if warranted. Any findings will be communicated before consenting to starting treatment, if appropriate. _____ *Initial*

I authorize Health From Within to contact me at all phone numbers / addresses listed on this intake form. If I do not wish to be contacted, I realize that I must notify Health From Within of this request _____ *Initial*

*I hereby authorize payment to be made directly to Health From Within for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this form or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Health From Within for any and all services I receive at this office. (*Does not apply to Medicare) _____ *Initial*

By my signature and initials below, I am acknowledging that Health From Within conforms with all current HIPAA guidelines and I may request a copy of the HIPAA policy from the front desk. _____ *Initial*

FEMALES - I acknowledge that as of today's date (please circle): **NO** I'm NOT pregnant / **YES** I'm pregnant

The statements made on this form are accurate to the best of my recollection.

Consenting Adult's Name Signature Date

Doctor's Name Signature Date Form Reviewed