

## New Patient Intake Form

### General Information

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  Male  Female  Other identity: \_\_\_\_\_  
 Marital Status:  Single  Married  Divorces  Widowed/Widower  Other: \_\_\_\_\_

### Employer Information

Employment Status:  Employed  Unemployed  Student  Other: \_\_\_\_\_  
 Your Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

### Spouse Information

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

### Emergency Contact Information

Same as spouse information

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

### Insurance Information

Do you have health insurance?  No  Yes

Name of party responsible for payment:  I am responsible  Same as spouse information

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Health Insurance Company Name: \_\_\_\_\_ Member ID: \_\_\_\_\_  
 Auto/Worker Comp Insurance: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

### Signatures

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Spouse's or guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Review of Systems**

**Have you had any of the following respiratory (breathing) issues?**

- Asthma/difficulty breathing
- COPD
- Emphysema
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following cardiovascular (heart-related) issues or procedures?**

- Heart surgeries
- Congestive heart failure
- Murmurs or valvular Disease
- Heart attacks/MIs
- Hypertension
- Pacemaker
- Irregular heartbeat
- Heart disease/ problem
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following neurological (nerve-related) issues?**

- Visual changes/loss of vision
- History of seizures
- Headaches
- Memory loss
- Loss of sense of smell
- One-side weakness of face or body
- Tremors
- Stroke/TIAs
- One-sided decreased feeling in the face or body
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following endocrine (glandular/hormonal) issues or procedures?**

- Thyroid disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following renal (kidney-related) issues or procedures?**

- Renal calculi/stones
- Hematuria (blood in urine)
- Incontinence (can't control)
- Dialysis
- Difficulty urinating
- Kidney disease
- Bladder infections
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following gastroenterological (stomach-related) issues or procedures?**

- Nausea
- Difficulty swallowing
- Ulcerative disease
- Frequent abdominal pain
- Hiatal hernia
- Constipation
- Pancreatic disease
- Hepatitis or liver disease
- Vomiting blood
- Bowel incontinence
- Bloody or black tarry stools
- Gastroesophageal reflux/heartburn
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following hematological (blood-related) issues or procedures?**

- Anemia
- HIV positive
- Abnormal bleeding/bruising
- Sickle-cell anemia
- Hemophilia
- Hypercoagulation or deep venous thrombosis/history of blood clots
- Enlarged lymph nodes
- Anticoagulant therapy
- Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
- Regular aspirin use
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following oncological (cancer-related) issues?**

- Abnormal bleeding/bruising
- Fevers/chills/sweats/unexplained weight loss
- Current/past oncology disease:
- Other \_\_\_\_\_
- None of above

**Have you had any of the following dermatological (skin-related) issues?**

- Significant burns
- Significant rashes
- Skin grafts
- Psoriatic disorder
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following musculoskeletal (bone/muscle- related) issues?**

- Rheumatoid arthritis
- Broken bones
- Osteoarthritis
- Gout
- Spinal fracture
- Arthritis (unknown type)
- Scoliosis
- Metal implants
- Spinal surgery
- Joint surgery
- Other \_\_\_\_\_
- None of the above

**Have you had any of the following psychological issues?**

- Psychiatric diagnosis
- Depression
- Suicidal ideations
- Bipolar disorder
- Homicidal ideations
- Schizophrenia
- Psychiatric hospitalizations
- Other \_\_\_\_\_
- None of the above

**Is there anything else in your past medical history that you feel is important to your care here?**

**Medications: (You may provide own medication list)**

Medication	Reason for taking

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

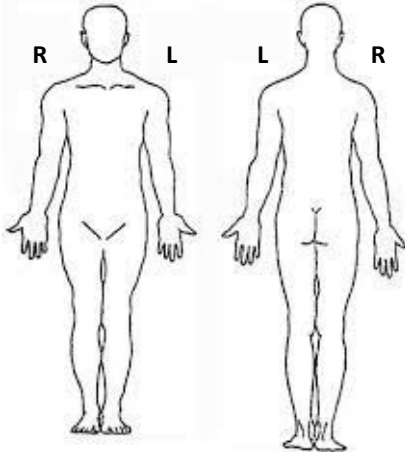
**NEW PATIENT HISTORY FORM**

• Did the symptom begin  suddenly or  gradually?

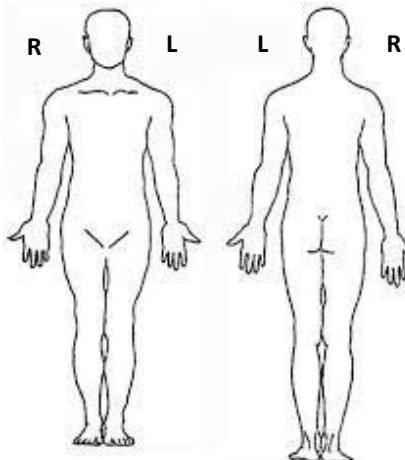
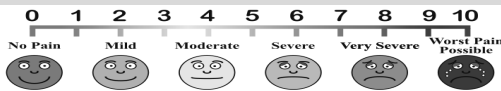
- When did the symptom begin? \_\_\_\_\_
- How did the symptom begin? \_\_\_\_\_

In diagram below, use the following letters to indicate **Type** and **Location** of your symptoms.

- A= Ache      O= Other  
 B= Burning    P= Pins & Needles  
 N= Numbness   S= Stabbing/Sharp



In diagram below, use the following number pain scale to indicate your symptom **Intensity** and **Location**.



N= Neck and Upper Back    M= Mid-Back    L= Lower Back

What makes the symptoms worse?	N	M	L	What makes the symptoms better?	N	M	L
arm movement				acupuncture			
arm position				arm position			
bending backwards				assistive device			
bending at the waist				back bend			
clinching / grinding teeth				back support / brace			
computer work				chiropractic care			
coughing				cold (ice pack)			
driving				exercise			
exercise				foam rolling			
getting in or out of bed				heat			
holding baby				icy/hot cream			
house work				knee to chest			
lifting object				lying on back			
lifting leg (right/left/both)				lying on side (right or left)			
lying on back				massage			
lying on side (right or left)				medication			
poor posture				movement			
reaching				popping back			
reading				popping neck			
resting				resting			
rolling in bed				running			
sit to stand				sitting			
sitting				sleeping			
sleeping				standing			
stair climbing				stretching			
standing				TEN's unit			
stress				upright posture			
stretching				Walking			
twisting				warm bath			
using smartphone or tablet				warm car seat			
walking				warm shower			
yardwork				yoga			
nothing				nothing			
Other:				Other:			

• Is the symptom worse at certain times of the day or night?

- No difference    Morning    Afternoon    Evening    Night    As the day progresses   Other: \_\_\_\_\_

• What percentage of the time do you experience the above symptom (s):

0 - 5 - 10 - 15 - 20 - 25 - 30 - 35 - 40 - 45 - 50 - 55 - 60 - 65 - 70 - 75 - 80 - 85 - 90 - 95 - 100

• Pain with movement?

Back	<input type="checkbox"/> bending forward	<input type="checkbox"/> bending back	<input type="checkbox"/> bending right	<input type="checkbox"/> bending left	<input type="checkbox"/> rotating right	<input type="checkbox"/> rotating left
Neck	<input type="checkbox"/> bending forward	<input type="checkbox"/> bending back	<input type="checkbox"/> tilting right	<input type="checkbox"/> tilting left	<input type="checkbox"/> rotating right	<input type="checkbox"/> rotating left

• Does symptom radiate to another part of your body?  yes    no

If yes, where does the symptom radiate? \_\_\_\_\_