

New Patient Intake Form

Date _____

Name _____ Address _____

Apt.# _____ City _____ State _____ Zip Code _____

E-Mail _____ Referred By _____

Cell Phone _____ Home Phone _____ Work Phone _____

Age _____ Birth Date _____ Marital: M S W D How many Children? _____

Occupation (if dependent list parent's occupation) _____

Employer _____ Address _____

Name of Spouse _____ Occupation _____

Employer _____ Office Phone _____ Other Phone _____

Emergency Contact _____ Phone _____ Other Phone _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT! q Cash q Check q Visa/MC

Person responsible for payment

Name _____ Phone _____ Other _____

Address _____ City _____ Zip _____

Are you Insured?	q YES	q NO	Insurance Company
------------------	-------	------	-------------------

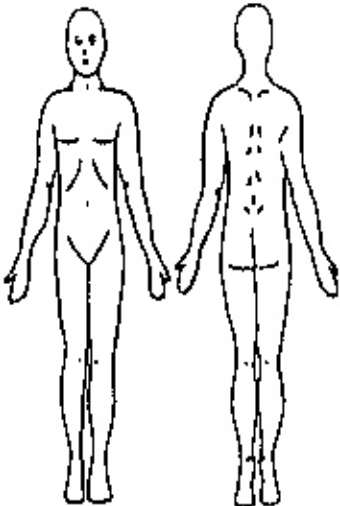
Other Doctors seen for this Condition _____

Have you been treated for any health condition by a physician in the last year? q YES q NO

Describe _____

Communication Channels: To help us better explain your chiropractic condition and how we may be able to help you, please check the best answer:

1. I remember important things in my life by: q what I see q what I hear q what I feel
 2. The primary reason I brush my teeth is to: q avoid tooth decay and gum disease
q make sure I have healthy teeth and gums
 3. When I make decisions I generally: q gather facts and weigh the evidence q make the right choice instantly
q consult my friends & family q depends on how I “feel” about it
- Hobbies:



Confidential Health History

Please outline on the diagram the area of your discomfort.

Please describe your present complaints

Is this a work related injury? q YES q NO

When did your present complaints occur? _____

Who has treated you for this condition (if anyone)? _____

Is this condition interfering with your q Work q Sleep q Recreation Dates missed: _____

Have you had this condition or similar conditions in the past? q YES q NO If so, when? _____

—

What treatment did you receive? _____

Name & location of previous chiropractor: _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Please check any of the following that apply to your current/past medical history:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio | <input type="checkbox"/> Dentures | <input type="checkbox"/> Eczema/Hives |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sprained ankle | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Vomiting of blood | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Depression | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Low backache | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Painful tailbone | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Surgery | <input type="checkbox"/> Numbness in arms/hands |
| <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Stiff or painful neck | <input type="checkbox"/> Weakness in arms | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Bad posture | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Burning sensations | |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Enlarged Glands | | |
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Gout | | |
| <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Nasal congestion | | |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Itching | | |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Chronic cough | | |
| <input type="checkbox"/> Poor urine control | <input type="checkbox"/> Heart disease | | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Hemorrhoids | | |
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Cancer | | |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Belching or gas | <input type="checkbox"/> Chest pain | | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting | | |
| <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Broken bones | | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness in legs | | |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Rheumatic fever | | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sinus infection | | |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Convulsions | | |

For Women Only:

- | | |
|---|---|
| <input type="checkbox"/> Premenstrual tension | <input type="checkbox"/> Unable to get pregnant |
| <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Excessive flow | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Irregular cycle |

Is there a possibility that you may be pregnant? q YES q NO
Date of last menstrual period _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Hetrick Chiropractic will help me to prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Hetrick Chiropractic will be to my account on the receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____