CONFIDENTIAL NEW PATIENT INTAKE FORM

Name (first, middle, last) ____ **Date** ___________________
Home Phone ____________________ **Work Phone** ________________ **Cell** ___________________
Which of the above numbers do you wish to be contacted at? ______________________________
Address ______________________________**City** _________________ **State** ____ **Zip** ___________
Email Address____
Birth date ______________ **Age** _______ **Marital Status** M S W D **# of Children** ___________

Preferred Language: _____________ **Race** (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (circle one) Every Day / Occasional / Former / Never Smoked

Soc. Sec. # ________________ **Employer** __________________ **Occupation** ___________________
Work Address __________________________________ **City** _________________ **Zip** ___________

Emergency Contact ____________________ Relationship ______________ Phone_________________
Name of Insured_____________________________ Birthdate_____________ SSN_______________

How did you hear about our clinic? ____
Have you ever had chiropractic care before? Y N Name of last chiropractor ______________________

SYMPTOMS

Major area of complaint ____

Pain is (circle all that apply):

Dull/Achy Sharp Numbness and/or Tingling Throbbing Constant

Intermittent Occasional Worse with motion Varies in intensity

Have you ever had this problem before? [ ] Yes [ ] NO If so, when? ___________________________
When did the pain/problem start? ______________________________________ [ ] Gradual [ ] Sudden
What do you think caused this problem? ____
Is the problem getting: **better** **worse** **no change** over time?
Do your symptoms interfere with: ______ Work ______ Sleep _______Activities ______ Chores
How ____
What increases your pain? ____________________What decreases your pain? ___________________

On a scale of 1-10 (10 being the most severe) please rate the severity of your symptoms:

1 2 3 4 5 6 7 8 9 10

List any other complaints currently bothering you and rate your pain level for each.

A ___________________________________ 1 2 3 4 5 6 7 8 9 10
B ___________________________________ 1 2 3 4 5 6 7 8 9 10
C ___________________________________ 1 2 3 4 5 6 7 8 9 10
D ___________________________________ 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Are you receiving care from other health professionals? [ ] Yes [ ] NO

If yes, please name them and their specialties ____

Have you ever been involved in a car or work-related accident? ________________________________

Have you had any previous surgeries? Please list type and date:________________________________

____

If you have experienced any of the following conditions in the past mark a “P” on the line provided. If you are currently experiencing any of the following conditions please mark a “C” on the line provided.

First Name:______________________________ **Last Name**:______________________________

___Headaches ___Diarrhea ___Sinus problems ___Asthma
___Migraines ___Constipation ___Ulcers ___Dribbling of urine
___Neck pain ___Mid back pain ___Low back pain ___Frequent urination
___Sciatica ___Arthritis ___Dizziness ___Lo/High blood pressure
___Fatigue ___Diabetes ___Nausea ___Hemorrhoids
___Chest Pain ___Loss of balance ___Ears Ring ___Sudden weight loss
___Heart attack ___Gout ___Cancer ___Pins&Needles in arms
___Kidney stones ___Menstrual cramps ___Ankle sprains ___Pins & Needles in legs
___Thyroid ___Osteoperosis
___Indigestion/Acid Reflux ___Double vision/Floaters/Blurry vision

Other ____

General activities (check all that apply)

___sleep on stomach ___read in bed ___fall asleep in recliner/on couch
___sleep on waterbed ___sewing ___needlepoint/knitting
___exercise _____x/wk ___smoke __packs/day ___drink alcohol _drinks/day
___drink coffee ___cups/day ___computer use __hours/day

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

For Women

Are you pregnant? **Y N**

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

For office use only ____ ____________________

Signature Date

Height: ________ Weight:___________ Blood Pressure:_____ /_____

If pregnant, Due Date: _____________ Name of OBGYN or Midwife _______________________________

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

____ ___________________________

Signature (Parent's Signature if Patient is a Minor) Date

Clinical Summary

☐ I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

HIPAA (Health Insurance Portability Accountability Act)

Calls, Open Room Adjusting & Health Care Information

Dr. Leahy and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. You may request a private room for your visits.

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (#164.524).

This notice is effective as of __________________, 20_____. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature ____ Date ________________