CONFIDENTIAL NEW PATIENT INTAKE

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** _____

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. Please circle conditions for which medications are taken for:

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

Other _____

General activities (check all that apply)

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

For Women

Are you pregnant? **Y N**

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

_____ _____
Signature Date

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

HIPPA (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 _____