HNS Chiropractic New Patient Intake Form

Patient Data **Date** _____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth ____/____/_____ **Sex:** Male Female

Social Security Number: _____-____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other____

Spouse Data

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

Doctor's Signature _____

Patient Name _____ **Date** _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never

Other _____

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

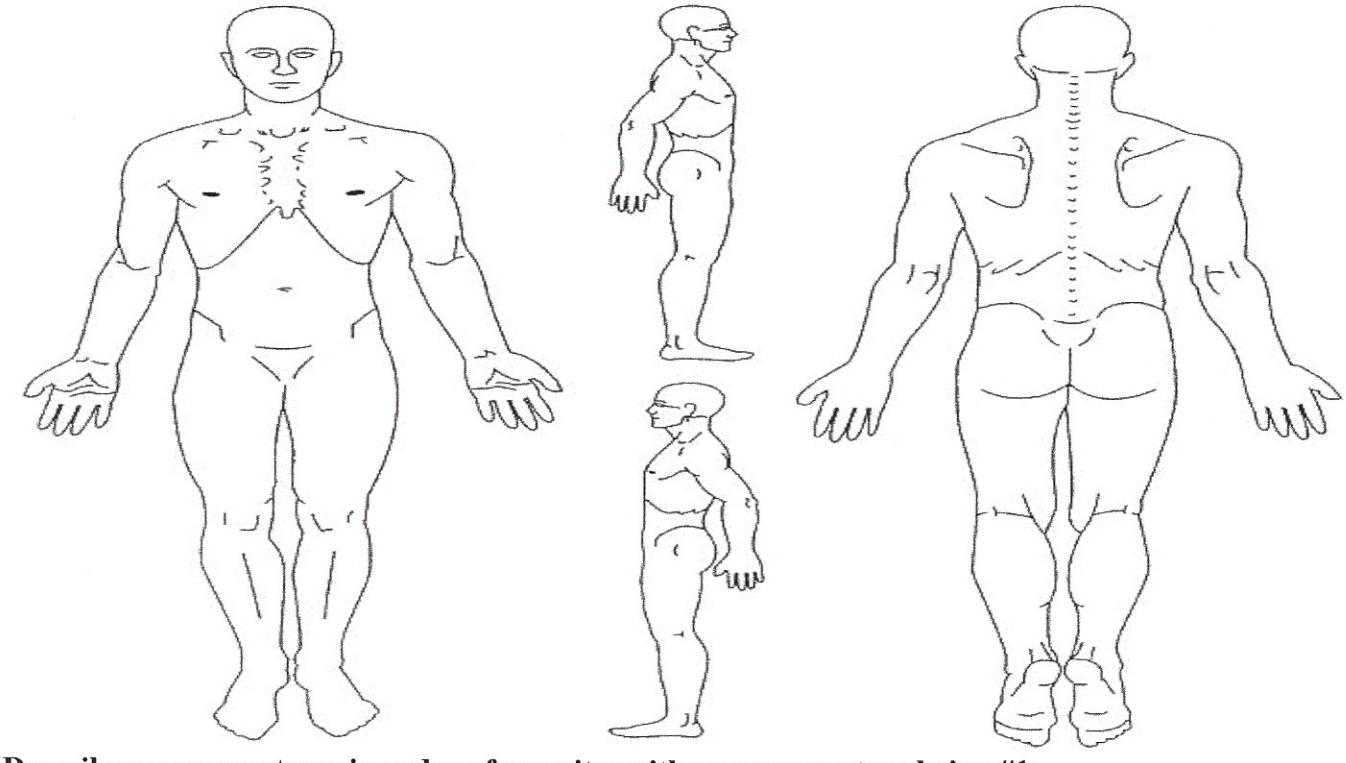
Doctor's Signature _____

Patient Name _____ **Date** _____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Doctor's Signature _____

Patient Name _____ **Date** _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

SIGNATURE OF PHYSICIAN: _____ **Date:** _____