Dear Patient,

The form below is our Patient Intake form that you will need to fill out for our office.

You may print this two sided form at home and fill it out before you come. This will save you time in our office during your 1st visit.

<u>Printing Instructions</u>:
Page 2 is the front side of the form and
Page 3 is the back side of the form.

Please, print these on 2 sides of one sheet of paper if possible.

Thank you and we look forward to meeting you face to face.

CONFIDENTIAL PATIENT INFORMATION
FAMILY CHIROPRACTIC CARE

Date _____

Last Name _____ Social
First _____ MI _____ Security ☐☐☐ ☐☐ ☐☐☐☐ Home Phone (____) _____
Cell Phone (____) _____

Address _____ City _____ Zip Code _____

Age _____ Birth Date _____ M F Marital Status: M S W D How Many Children? _____

E-mail _____ Spouse (or Parent if Minor) _____

Occupation _____ Employer _____

Employer _____ Work Phone _____

Work Phone _____ Address _____

Address _____ Emergency Contact _____

Referred by _____ Emergency Phone (____) _____

Purpose of this appointment/current problem _____

Other doctors seen for this condition _____

Is the condition due to injury or sickness arising out of employment or auto accident? _____

Date symptoms appeared or accident happened: _____ Days lost from work? ( ) YES ( ) NO

Have you ever suffered from:

1. Dizziness _____ 5. Neck Pain _____ 9. Nervousness _____ 13. Shoulder/Arm Pain _____
2. Arthritis _____ 6. Back Pain _____ 10. Hip/Leg Pain _____ 14. Urinary Problems _____
3. Cancer _____ 7. Headaches _____ 11.Sinus Trouble_____ 15. Male/Female Troubles _____
4. Diabetes _____ 8. Numbness _____ 12.Heart Trouble _____ 16. Digestive Disorders_____

Do you smoke? ( ) NO ( ) YES _____ packs/day Do you have a pacemaker? ( ) YES ( ) NO

Do you drink alcohol? ( ) NO ( ) YES _____ drinks/week

Have you been treated for any health condition by a physician in the last year: ( ) YES ( ) NO

Describe _____

Date of last physical examination _____ List surgeries _____

Serious illnesses _____

What medications or drugs are you currently taking? _____

If female, are you taking birth control pills? ( ) YES ( ) NO Pregnant? ( ) YES ( ) NO

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to Family Chiropractic Care to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____

Patient Signature (or Guardian Signature Authorizing Care) Date

Insurance Company _____ Insured _____ SS# _____

1. What is your major symptom? _____
2. When was the first time you noticed this problem? _____
3. What may have caused it? _____

   Has it become worse recently? _____ If yes, when and how? _____
4. Have you ever had the same or a similar condition: ( ) Yes ( ) No
5. If yes, when and describe: _____
6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting?

   (other) _____
7. Is there anything you can do which seems to provide relief? _____

   _____
8. What makes the problem worse? _____
9. Is your condition Constant = (gets better and worse but never completely goes away)

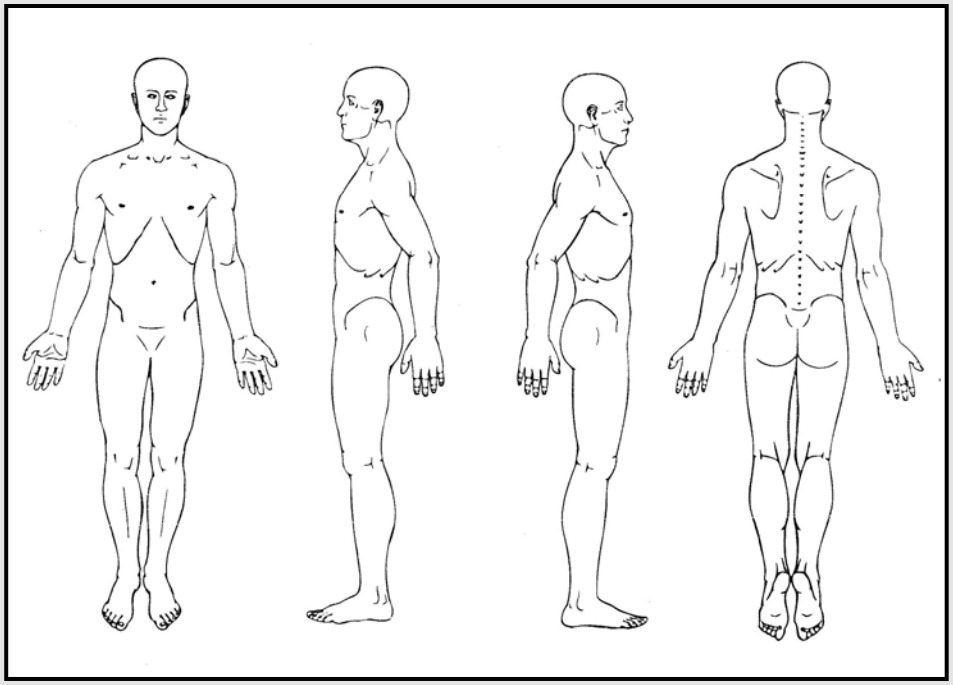
   Circle one Intermittent = (gets bad, gets better, goes away but comes back again)

   How long does it last? _____ How often does it occur? _____
10. List accidents, major illnesses, surgeries, or broken bones. _____

    _____
11. Are there any conditions or symptoms you have that may be related to your major symptom?

    _____

12. **Please Mark Your Symptom Areas**



13. **Rate the Severity of Your Condition**

- 10 out of 10
- 9 out of 10 (Stops all activity)
- 8 out of 10
- 7 out of 10
- 6 out of 10 (Stops some activity)
- 5 out of 10
- 4 out of 10
- 3 out of 10 (Forgotten with activity)
- 2 out of 10
- 1 out of 10
- 0 out of 10 (None)