

Health Center of Hillsborough
401 MEADOWLANDS DRIVE
HILLSBOROUGH, NC 27278
919-241-5032
www.youhealit.com
CHIROPRACTIC • ACUPUNCTURE •
NUTRITION • MASSAGE

New Patient Intake Form

Patient 1

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** (____) _____ - _____

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 _____			

Patient Name _____

Date _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No	Difficulty Swallowing	Past	Present	
Irregular Heartbeat					Past	Present		Dizziness			
Swelling of legs				Glaucoma				Hearing Loss			
				Double Vision				Sore Throat			
Genitourinary			No	Blurred Vision				Nosebleeds			
	Past	Present						Bleeding Gums			
Kidney Disease				Psychiatric			No	Sinus Infections			
Burning Urination					Past	Present					
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

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:

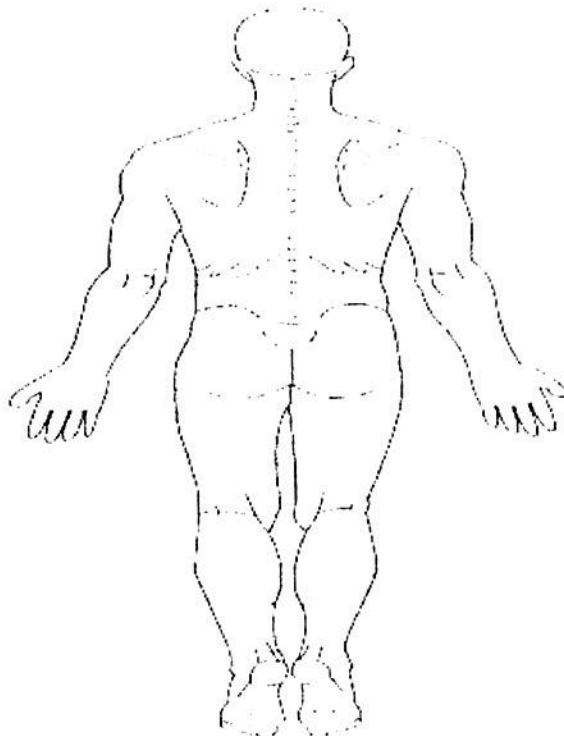
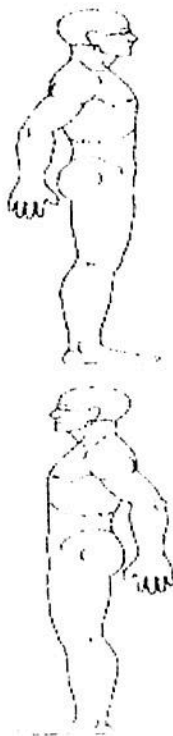
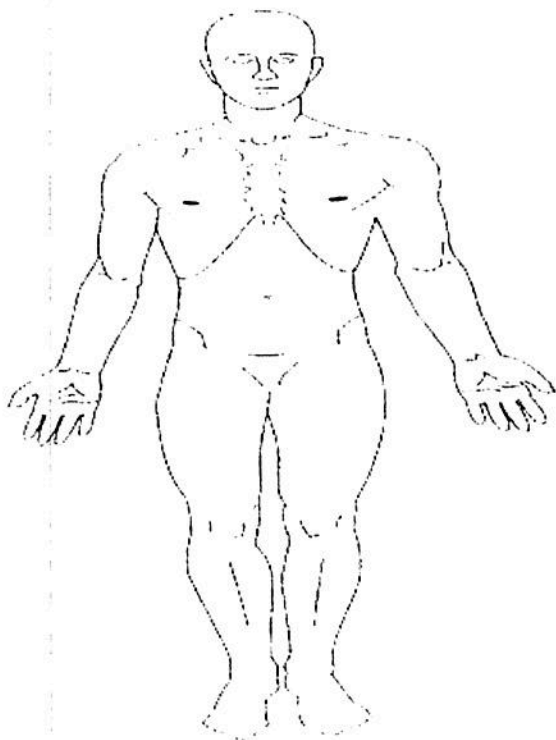
N=Numbness

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
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

What describes the nature of your symptoms?

Sharp
Burning

Dull ache
Tingling

Numb
Stabbing

Shooting
Other _____

Patient Name _____

Date _____

How are your symptoms changing?

Getting better

Not changing

Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ Score _____

Description of Work: _____

Condition's Effect On Job Performance: No Effect Mild (painful can do) Mod (painful limited ability)
 Mod/Sev (limited duty) Sev (no limited duty) Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care --Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn-Sit-Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care--Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care--Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care--Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

Patient Name _____

Date _____

Payment/Insurance Information:

Who is responsible for your bill? Self Spouse Worker's Comp
Auto Insur. Medicare

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:** _____