New Patient Intake Form

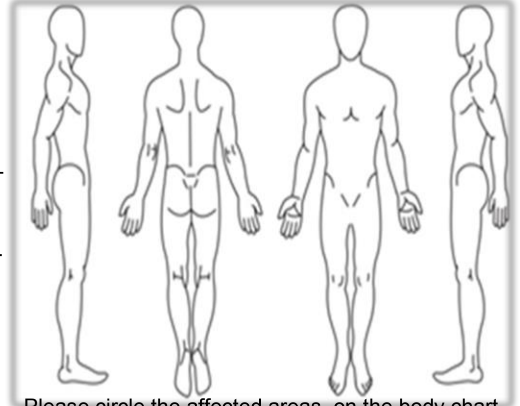
NEW HOPE CHIROPRACTIC

Name:_________________________________ DOB:_________ Age: _____ Sex:_____
Address: ____ SS#: ____________________
City:___________________ State:_____ Zip code:_________ Occupation: ____________
Phone: _______________________ (mobile/home /work) alternate #: ___________________
Email Address:____
Emergency Contact: _____________________ relationship:________ Phone #: _____________

How were you referred to our office?

- Yelp
- New Hope website
- Patient referral: ________________
- Other: ________________

This visit is a result of __ auto __ work __ injury __ other Date of Onset: ___________
What seems to be the initial cause? ______________________________________
____
How long have you had this condition? ____________________________________
Is it getting worse? ____ Yes ____ No ___________________________________
Which activity do you have a difficult time doing? __________________________
What percent of the day do you experience the problem?
___ 0-25% (intermittent) ___ 26-50% (occasionally) ___ 51-75% (frequently) ___ 76-100% (constantly)
Brief description of the problem: ____
____
____
Have you received any treatment for this current problem? ____________________



Please circle the affected areas, on the body chart.
Please mark the level of your pain on the scale below.
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Least possible pain Worst possible pain

Current Health History: (please place a check mark next to your condition)

__ Dizziness	__ Arthritis/Rheumatism	__ High cholesterol	__ Weight loss or gain more than 10 lbs. in 1 month.
__ Fainting	__ Rash/ itching on skin	__ Osteoporosis	__ Spinal compromise or instabilities
__ Fatiguing	__ Spinal fracture	__ Numbness	__ Urinate more than 8x in 24hrs
__ Fever	__ High blood pressure	__ Sinus problem	__ Sudden weakness in arms or legs
__ Headache	__ Low blood pressure	__ Ringing of the ears	__ Mental illness
__ Anemia	__ Cancer	__ Diabetes	

For women: __ menopause __ Dysmenorrhea __ Painful cramps/back pain
Are you pregnant: __ YES __ NO How many children do you have? ____

Habits

Smoking
none light mod. Heavy
Exercise
__ More than once a week
__ More than once a month
__ Less than once a month
Type of exercise: ___________
How is most of your day spent?
__ Sitting __ Standing __ other

Past Health History: (please place a check mark next to your condition)

__ Alcoholism __ Hernia __ Liver trouble
__ Colitis/Crohn's __ Osteoporosis __ Heart trouble
__ Chronic constipation __ Kidney problem __ stroke __ pace maker
__ Chronic diarrhea __ Prostate trouble

Have you…
...been hospitalized in the past 5 years? __ YES __ NO _______________
…had any surgeries? __ YES __ NO _________________
…had any mental disorders? __ YES __ NO _________________
…had any broken bones? __ YES __ NO _________________
…had any strains or sprains? __ YES __ NO _________________
…had any metal implants other than dental implants? __ YES__ NO _________________
Do you have any other health issues or concerns that our staff should be aware of?
____

Family Health History

(if any blood relatives has had any of the following conditions, please check and indicate which relatives)

___ alcoholism ___ multiple sclerosis
___ bleed easily ___ osteoporosis
___ arthritis ___ stroke
___ cancer ___ thyroid disease
___ diabetes ___ heart disease

Previous Chiropractor name: ______________________________ Areas treated: ________________
Primary Care Doctor: __________________________________ most recent physical exam: ____________
Current medication list (including supplements and vitamins): ________________________________
Dentist: ____ most recent exam: ______________

Print Patient Name: ____ **DOB:** ____/____/______

*If you will like a copy of the information sheets please ask and it will be provided to you.

Assignment of Benefits

Do you wish to process your insurance? ___ yes ____ no   If yes, please fill out the following.

I have read the information on the assignment of benefits (information sheet A-Pink) and have fully understood the material and have been given the chance to ask questions. I certify that all of the information that is provided in connection with this claim is true, complete and accurate.

Name of Insurance: ________________________________Member ID: _____________________

Subscriber name: ____Group#: __________________

Patient Signature: ____ Date: __________________

HIPAA Privacy Disclosure Consent

I have read your consent policy (information sheet A-pink) and agree to its terms.

Patient Signature: ____ Date: ____________

General Office Policy

I have read your consent policy (information sheet B-Blue) and agree to all the office policies.

Patient Signature: ____ Date: ____________

Informed Consent for Chiropractic Care

I have read the consent policy (information sheet B-Blue) and I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities.

I would like a copy of the Informed Consent for Chiropractic Care form: ____ Yes   ____ No

Patient Signature: ____ Date: ____________

Consent to Treatment of Minor

Patient is under 18 years of age: _____Yes ______ No   If yes, please fill out the following.

I hereby consent and authorize x-ray, examination, chiropractic diagnosis and/or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

Legal Guardian Signature: ____ Date: _____________

Name of guardian: ______________________________________ Relation to Minor: ____________

Office use only ver 2022

Patient file ID: ______________________________ Doctor _______ Chun _______ Roh _______ Jack

Authorized staff signature: ____ Date: ________________