# New Patient Intake Form

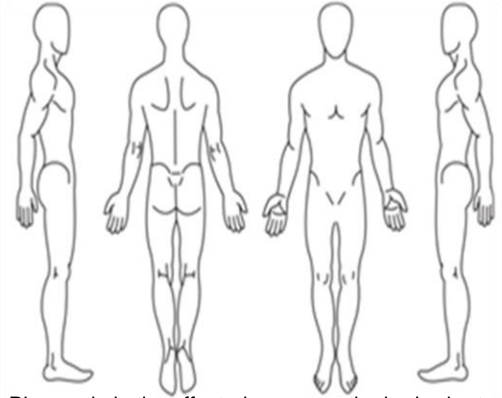
NEW HOPE CHIROPRACTIC

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 wit 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.

Patent Signature: _______________________________________________ Date: ___________

## General Office Policy

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

Patent 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

Patent 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: _______________