HERRMANN FAMILY CHIROPRACTIC

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New Patient Intake Form

Patient Information:

Name:_____ Date: _____/_____/_____
First Middle Last

Preferred Name:_____ Date of Birth _____/_____/_____ Gender ☐ M ☐ F

Cell (_____)_____-_____ Home/Other (_____)_____-_____Email:_____

Address:_____
Street City State Zip

Marital Status: _____ Spouse's Name (if applicable)_____ # of Child(ren) _____

Emergency Contact:_____ Relation:_____ Phone (_____)_____-_____

Employer/School Information:

Employed: ☐full-time ☐ part-time ☐ unemployed Occupation:_____

Employer:_____ City, State:_____ Phone (_____)_____-_____

Student: ☐full-time ☐ part-time School/College:_____ Grade/Level:_____

Insurance Information (*complete if insurance card is not present at the first visit*):

Insurance Name:_____Member ID:_____ Group Number:_____

Name of Policy Holder:_____ Policy Holder Birthday ____/____/____

Relation to Holder:_____ Effective Date: ____/____/____ Policy Holder Phone: (_____)_____-_____

Policy Holder Address:(☐same as above)_____
Street City State Zip

Reason(s) for Visit:_____

Describe your symptoms: _____

_____

Rate your discomfort on a scale of 0 (no discomfort) to 10 (worst possible discomfort):_____

Describe incident/progression (if any):_____

When did this begin? ____/____/____ Since it started, has it gotten: ☐ better, ☐ worse, or ☐ stayed the same?

Have you experienced this before? ☐No ☐Yes (explain)_____

Have you sought care from another provider for this concern? ☐No ☐Yes (explain)_____

_____

Chiropractic Experience:

Have you been adjusted by a chiropractor before? ☐Yes ☐No Date of last adjustment: ____/____/____

Chiropractor:_____ Location:_____
Chiropractor and/or office name City, State

How did you hear about our office? ☐Website ☐Facebook ☐Email ☐Drive/Walk by ☐Insurance Website

☐Family/Friend:_____☐Community Event: _____☐Other: _____

Personal Health History:

Primary Care Physician:_____ Date of last physical: ____/____/____
Physician and/or office name

Office Phone: (_____)_____-_____ City, State:_____

Current Illnesses:_____

Previous illnesses:_____

Current medications: (Rx & OTC)_____

Supplements/Vitamins:_____

Personal Incident History *(include relative dates or ages):*

Surgeries ☐No ☐Yes (explain)_____

Broken Bones ☐No ☐Yes (explain)_____

Sprains/Strains ☐No ☐Yes (explain)_____

Hospitalizations ☐No ☐Yes (explain)_____

Auto Accident ☐No ☐Yes (explain)_____

Struck Unconscious ☐No ☐Yes (explain)_____

Stroke ☐No ☐Yes (explain)_____

Heart Attack ☐No ☐Yes (explain)_____

Psychological Disorder ☐No ☐Yes (explain)_____

Social History:

Alcohol:	☐No ☐Yes, _____	Drinks	per	☐Day	☐Week	☐ Month
Caffeine:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Cigarettes:	☐No ☐Yes, _____	Packs	per	☐Day	☐Week	☐ Month
Drugs:	☐No ☐Yes, _____		per	☐Day	☐Week	☐ Month
Exercise:	☐No ☐Yes, _____	Minutes	per	☐Day	☐Week	☐ Month
Fruits/Vegetables:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Processed Foods:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Restaurants:	☐No ☐Yes, _____	Meals	per	☐Day	☐Week	☐ Month
Soda/Pop:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Tobacco:	☐No ☐Yes, _____		per	☐Day	☐Week	☐ Month
Water:	☐No ☐Yes, _____	Ounces	per	☐Day	☐Week	☐ Month

Health Checklist (mark all that apply, *past and present*):

Musculoskeletal
- ☐ Ankle Pain/Injury
- ☐ Arthritis (Type:_____)
- ☐ Back Pain
- ☐ Cramps
- ☐ Disc Herniation
- ☐ Dislocation (Type:_____)
- ☐ Elbow Pain/Injury
- ☐ Joint Pain
- ☐ Knee Pain/Injury
- ☐ Muscle Pain
- ☐ Muscle Spasm
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Plantar Fasciitis
- ☐ Scoliosis/Spinal Curves
- ☐ Shoulder Pain/Injury
- ☐ Spinal Stenosis
- ☐ Sprains/Strains
- ☐ Swelling of Joints
- ☐ TMJ dysfunction/syndrome
- ☐ Whiplash
- ☐ Wrist Pain/Injury

Neurological
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Carpal Tunnel Syndrome
- ☐ Cerebral Palsy
- ☐ Concussion/Head Injury
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Headache
- ☐ Insomnia/Sleep Issues
- ☐ Loss of Balance
- ☐ Loss of Consciousness
- ☐ Loss of Hearing
- ☐ Loss of Memory
- ☐ Loss of Smell/Taste
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Numbness (Location:_____)
- ☐ OCD
- ☐ Panic Attacks
- ☐ Parkinson's
- ☐ Pins & Needles
- ☐ PTSD
- ☐ Sciatica
- ☐ Seizures
- ☐ Stroke/CVA/TIA
- ☐ Tremor
- ☐ Vertigo/Dizziness

Head/Neck
- ☐ Cataracts
- ☐ Ear Infections
- ☐ Eye pain/problems
- ☐ Frequent Colds
- ☐ Glasses/Contacts
- ☐ Headache
- ☐ Hearing Aids
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Nosebleeds
- ☐ Retinal Disease
- ☐ Sinus Infection
- ☐ Tinnitus/Ear Ringing

Heart/Lungs/Chest/Circulation
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain/Angina
- ☐ CHF
- ☐ Cold Hands/Feet
- ☐ COPD/Emphysema
- ☐ Irregular Heart Beat/Murmur
- ☐ Lung Disease
- ☐ Pacemaker
- ☐ Shortness of Breath
- ☐ Smoker
- ☐ Swelling of Ankles/Feet

Gastrointestinal
- ☐ Acid Reflux/Heartburn
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Encopresis
- ☐ Food sensitivities
- ☐ Indigestion
- ☐ Irritable Bowel Syndrome
- ☐ Ulcer

Genitourinary
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular Menstrual Cycle
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ PMS/PMDD
- ☐ Prostate Complications
- ☐ STD/STI
- ☐ Urinary Frequency
- ☐ UTI

Skin
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Sensitivity

Systemic/Constitutional
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Cancer (Type:_____)
- ☐ Chronic Fatigue
- ☐ Coronary Artery Disease
- ☐ Diabetes (Type:_____)
- ☐ Gout
- ☐ Hemorrhoids
- ☐ Hernia (Type:_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Hot Flashes
- ☐ Liver Disease/Cirrhosis
- ☐ Osteoporosis
- ☐ Thyroid Condition
- ☐ Varicose Veins

Other:

_____
_____
_____

For Women Only (*answer all that apply*):

Are you pregnant, trying to become pregnant, or nursing? ☐No ☐Yes. If so, which:_____

Do you experience painful periods? ☐No ☐Yes Are your periods regular? ☐Yes ☐No

Do you use contraceptives? ☐No ☐Yes, type:_____ Do you perform self-breast examinations? ☐Yes ☐No

# of pregnancies:_____ # of births: _____ # of children: _____

Pregnancy complications:_____

Have you experienced menopause? ☐No ☐Yes. If so, when:_____

Date of last: menstrual period ____/____/____ PAP____/____/____ Mammogram____/____/____

Family Health History (*include significant diseases and genetic disorders if known*):

	Condition(s)	Age	Alive or Deceased
Mother			☐ Alive ☐ Deceased
Father			☐ Alive ☐ Deceased
Sibling(s)			☐ Alive ☐ Deceased
Maternal Grandmother			☐ Alive ☐ Deceased
Maternal Grandfather			☐ Alive ☐ Deceased
Paternal Grandmother			☐ Alive ☐ Deceased
Paternal Grandfather			☐ Alive ☐ Deceased
Other			☐ Alive ☐ Deceased

What are your health goals (i.e., lose weight, resolve health problems/symptoms, more energy, etc.)?

_____

_____

_____

I certify that I am the patient or legal guardian of the patient listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Herrmann Family Chiropractic. I authorize this office and its staff to examine and provide care for my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care.

Signature of patient or parent/guardian:_____ Date:____/____/____

Printed name of parent/guardian:_____ Relation to patient:_____