



New Patient Intake Form

About You

Last Name: _____ First Name: _____ Middle Initial: _____
 Preferred Name: _____ Date of Birth: _____ Age: _____ Gender: M F
 Phone: (H) _____ (W) _____ (C) _____
 Address: _____ City: _____ State: _____ Zip: _____
 E-Mail: _____ Occupation: _____
 Marital Status: Single Married Divorced Widowed Other: _____
 Names and Ages of Children: _____
 Insurance: Work Comp Auto Medicare Private
 Emergency Contact: _____ Phone #: _____ Relationship: _____
 Who may we thank for referring you to us? _____
 How would you like appointment reminders sent: email text: cell provider _____

Your Health Profile

As a family chiropractic office, we focus on your ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you the opportunity of improved health and wellness potential.

What brings you to our office: _____

I have no symptoms or complaints and am here for **wellness services**

What are your health goals?

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

Is your current condition the result of: an auto accident? a work related injury?
Date of injury? _____

Primary complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? _____

When did these symptoms begin? _____

How would you describe the symptoms? _____

Please describe the location of the pain: _____

On a scale of 1-10 (10 most extreme) what is the average pain level? _____

Is this problem getting: worse? better? staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem? _____

Have you seen anyone for this problem? If yes, who? _____

What treatment was given? _____

How effective was the treatment? _____

Additional Complaints – (List anything else you'd like to discuss with the doctor):

Lifestyle/Social History

What physical activities do you perform during the day? (example: prolonged sitting, computer/desk, lifting, prolonged standing, etc...)

How many hours per week do you work? _____

What recreational activities/hobbies do you regularly engage in?

Do you smoke cigarettes? Y N If yes, how much? _____

Do you drink alcohol? Y N If yes, how much? _____

Do you drink coffee? Y N If yes, how much? _____

Do you drink tea? Y N If yes, how much? _____

How regularly do you exercise? daily ____x/week occasionally never

What kind of exercise do you do?_____

How many hours of sleep do you get on average?_____

On a scale of 0-10 please rate your stress level (0=none and 10=extreme):

Occupational ____ Personal ____

Medical History

Please check any of the following illnesses you have had:

- | | | | |
|--------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Thyroid Disorder |

Please check any of the following you have experienced in the **past 6 months**:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Headaches
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- High Stress

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIO-VASCULAR-RESPIRATORY

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose
- Hearing Difficulties

GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

- _____ Liver Problems
- _____ Gall Bladder Problems
- _____ Weight Trouble
- _____ Abdominal Cramps
- _____ Gas/Bloating after Meals
- _____ Heartburn
- _____ Black/Bloody Stools
- _____ Colitis

- MALE/FEMALE
- _____ Menstrual Irregularity
 - _____ Menstrual Cramps
 - _____ Vaginal Pain/Infection
 - _____ Breast Pain/Lumps
 - _____ Prostate/Sexual Dysfunction
 - _____ Other Problems:
-

Please give us any other health information you may feel would be helpful:

Surgeries

Date	Type and reason for surgery
_____	_____
_____	_____
_____	_____
_____	_____

Accidents or Injuries

Date	Details
_____	_____
_____	_____
_____	_____
_____	_____

Medications or Supplements Reason for taking

_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Women Only

Pregnancies and outcomes:

Date of pregnancy Outcome

_____	_____
_____	_____
_____	_____
_____	_____

Are you pregnant? Yes No Not sure

Authorizations and Releases

Patient's name: _____ Date of Birth: _____

Authorization and Agreement for Payment of Services Rendered:

I authorize Hollis Family Chiropractic Center, PLLC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claims for reimbursement of charges incurred by me.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account upon receipt.

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient's signature: _____ Date: _____

Informed Consent for Examination and Treatment

This document explains some potential risks associated with chiropractic care. Please read this information carefully, and let our staff know if you have questions.

The doctor and staff of Hollis Family Chiropractic Center, PLLC will do everything to assist you with your health, or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. Nor do we offer advice regarding a previous diagnosis or treatment prescribed by others. While Chiropractic care is remarkably safe, there are some risks associated with it, and we feel you need to be fully informed about these risks before consenting to treatment.

Soreness – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please advise your doctor if you experience this.

Soft Tissue Injury – Rarely, Chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.

Stroke – Stroke is the most serious complication of Chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of this type of stroke is one in five million neck adjustments.

Other Complications – There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctor and staff of Hollis Family Chiropractic Center, PLLC to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

Patient's signature: _____ Date: _____

(Parent or guardian, if patient under age 18)