Dr. Safina Hussain-Rahimi, D.C.
Healthy Movements Chiropractic
550 S. Watters Road, Suite 112
Allen, TX 75013
Phone: 972-632-9173
www.healthymovementschiropractic.com

NEW PATIENT INTAKE FORM

Welcome! Please complete all sections so we can provide you with the best possible care.

PATIENT INFORMATION

Date _____

Patient Name _____ (Last) _____ (First) _____ (Middle)

Address _____

City _____ State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Minor

☐ Partnered for _____ years

Occupation _____ Employer / School _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS & EMERGENCY CONTACT

Cell Phone _____ May we text you at this number? ☐ Yes ☐ No

Best time and place to reach you _____

In case of emergency, contact:

Name _____ Relationship _____

Cell Phone _____ Work Phone _____

INSURANCE

Who is responsible for this account? _____ Relationship _____

Insurance Co. _____ ID # _____ Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Birthdate _____

Relationship to Patient _____

Secondary Insurance _____ ID # _____ Group # _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker's Comp. ☐ Other

Attorney Name (if applicable) _____

Adjuster Name _____ Adjuster Phone _____ Claim # _____

PATIENT CONDITION

Reason for visit _____

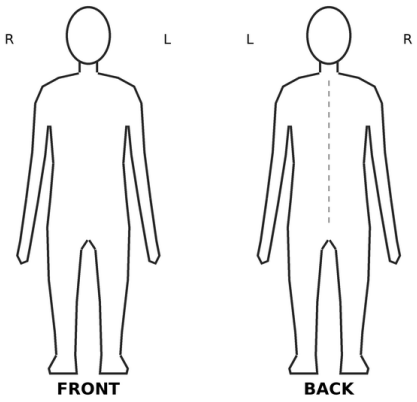
_____

When did your symptoms appear? _____

Is this condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain (circle one):

(least) **1 2 3 4 5 6 7 8 9 10** (severe)

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What makes it better? _____

What makes it worse? _____

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

☐ Other _____

Name and address of other doctor(s) who have treated you for your condition

_____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Rheumatoid Arthritis	☐	☐
Alcoholism	☐	☐	Emphysema	☐	☐	Measles	☐	☐	Rheumatic Fever	☐	☐
Allergy Shots	☐	☐	Epilepsy	☐	☐	Migraine Headaches	☐	☐	Scarlet Fever	☐	☐
Anemia	☐	☐	Fractures	☐	☐	Miscarriage	☐	☐	Sexually Transmitted Disease	☐	☐
Anorexia	☐	☐	Glaucoma	☐	☐	Mononucleosis	☐	☐	Stroke	☐	☐
Appendicitis	☐	☐	Goiter	☐	☐	Multiple Sclerosis	☐	☐	Suicide Attempt	☐	☐
Arthritis	☐	☐	Gonorrhea	☐	☐	Mumps	☐	☐	Thyroid Problems	☐	☐
Asthma	☐	☐	Gout	☐	☐	Osteoporosis	☐	☐	Tonsillitis	☐	☐
Bleeding Disorders	☐	☐	Heart Disease	☐	☐	Pacemaker	☐	☐	Tuberculosis	☐	☐
Breast Lump	☐	☐	Hepatitis	☐	☐	Parkinson's Disease	☐	☐	Tumors, Growths	☐	☐
Bronchitis	☐	☐	Hernia	☐	☐	Pinched Nerve	☐	☐	Typhoid Fever	☐	☐
Bulimia	☐	☐	Herniated Disk	☐	☐	Pneumonia	☐	☐	Ulcers	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Polio	☐	☐	Vaginal Infections	☐	☐
Cataracts	☐	☐	High Blood Pressure	☐	☐	Prostate Problem	☐	☐	Whooping Cough	☐	☐
Chemical Dependency	☐	☐	High Cholesterol	☐	☐	Prosthesis	☐	☐	Other		
Chicken Pox	☐	☐	Kidney Disease	☐	☐	Psychiatric Care	☐	☐	_____		

LIFESTYLE

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine
☐ High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Hobbies _____

Are you ☐ Right-handed ☐ Left-handed

Are you pregnant? ☐ Yes ☐ No Due Date _____

INJURIES / SURGERIES YOU HAVE HAD

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS, ALLERGIES & SUPPLEMENTS

Medications *List all prescription and over-the-counter medications*

Allergies *Medications, foods, latex, environmental, etc.*

Vitamins / Herbs / Minerals

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of insurance company(ies)) and assign directly to Dr. Safina Hussain-Rahimi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient