NEW PATIENT INTAKE

LIFE Source CHIROPRACTIC

Patient Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone (____) _____ **Cell (____)** _____ **Work (____)** _____

Email Address: _____ **Male**_____ **Female**_____

Birth Date: _____ **Age**_____ **Occupation:** _____

Single____ **Married**____ **Spouse's Name** _____

Family Doctor: _____ **Phone:** _____

Reason last seen? _____ **May we contact your doctor if necessary?** □ Yes □No

Whom may we thank for referring you to our office? _____

Do you have insurance? □ Yes □ No | HSA account? □ Yes □ No | Self-pay? □ Yes □ No

Are you the primary policy holder? □ Yes □ No | If 'No' please provide:

Policy holder name: _____ **Policy holder date of birth:** _____

YOUR HEALTH SUMMARY

What is your primary complaint? _____

Check all symptoms you have ever had even if they do not seem related to your primary complaint.

___Headaches	___Numbness in fingers	___TMJD	___Back Pain
___Pins and needles in arms	___Tension	___Loss of balance	___Heartburn
___Ringing in ears	___Numbness in fingers	___Dizziness	___Shoulder Pain
___Depression	___Tension	___Fatigue	___Pins and Needles in Legs
___Sleeping problems	___Neck Stiffness	___Vertigo	___Numbness in Toes
___Migraines	___Neck Pain	___Cold Hands	___Cold Feet

___ **Other:** _____

If this is due to an injury or auto accident, what is the date of injury or accident? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your condition worse? _____

What have you tried that has helped your condition? _____

Have you seen a chiropractor in the past? _____ **If yes, when?** _____

Any past surgeries or hospitalizations? _____

Please list any medications you are taking: _____

Is your pain Constant or Off and On During the day? _____

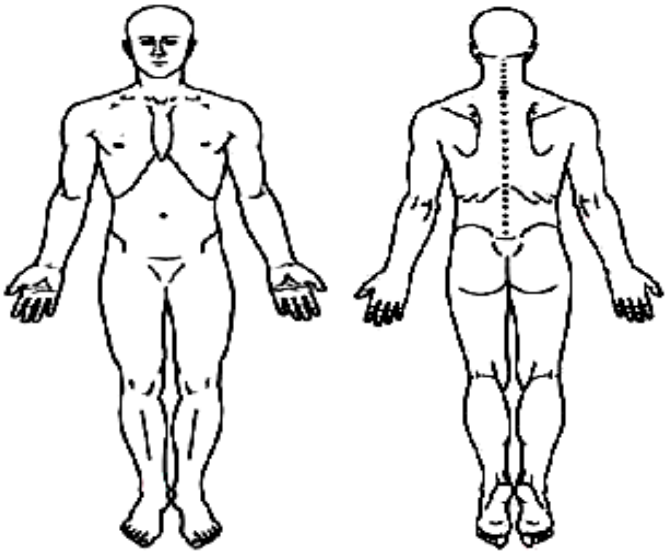
Grade Intensity/Severity: (Circle the number the best describes the pain)

(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Patient Name: _____ **Date:** _____

If you are in pain, please mark the exact location of your pain AND any other details about your pain on the diagram using the abbreviations listed below. If you need to make further descriptions use the 'other' box.

D = *dull* | *S = sharp* | *B = burning* | *A – Aching*



Other:

Authorization / Consent / Assignment of Benefits / HIPAA / Pregnancy

I _____ hereby grant permission to receive a chiropractic evaluation including history, posture evaluation, examination and x-rays if warranted. Any findings will be communicated before consenting to starting treatment, if appropriate. _____ *Initial*

I authorize Life Source Chiropractic to contact me at all phone numbers / addresses listed on this intake form. If I do not wish to be contacted, I realize that I must notify Life Source Chiropractic of this request _____ *Initial*

*I hereby authorize payment to be made directly to Life Source Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this form or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Life Source Chiropractic for any and all services I receive at this office. *(*Does not apply to Medicare)* _____ *Initial*

By my signature and initials below, I am acknowledging that Life Source Chiropractic conforms with all current HIPAA guidelines and I may request a copy of the HIPAA policy from the front desk. _____ *Initial*

FEMALES - I acknowledge that as of today's date (please circle): **NO** I'm NOT pregnant / **YES** I'm pregnant

The statements made on this form are accurate to the best of my recollection.

_____	_____	_____
Consenting Adult's Name	Signature	Date
_____	_____	_____
Doctor's Name	Signature	Date Form Reviewed

Functional Rating Index

For use with Neck and/or back problems only. In order to properly assess your condition , we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

9. Pain Intensity

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

10. Recreation

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

8. Sleeping

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

4. Frequency of Pain

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

7. Personal Care (washing, dressing, etc)

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

3. Lifting

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

6. Travel(driving, etc)

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

2. Walking

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

5. Work

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

1. Standing

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst possible Pain

Name _____

_____ _____

Signature Date