

# NEW PATIENT INTAKE



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.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> TMJD            | <input type="checkbox"/> Back Pain                |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Tension             | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Heartburn                |
| <input type="checkbox"/> Ringing in ears          | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Shoulder Pain            |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Tension             | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Pins and Needles in Legs |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck Stiffness      | <input type="checkbox"/> Vertigo         | <input type="checkbox"/> Numbness in Toes         |
| <input type="checkbox"/> Migraines                | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Cold Hands      | <input type="checkbox"/> 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? \_\_\_\_\_

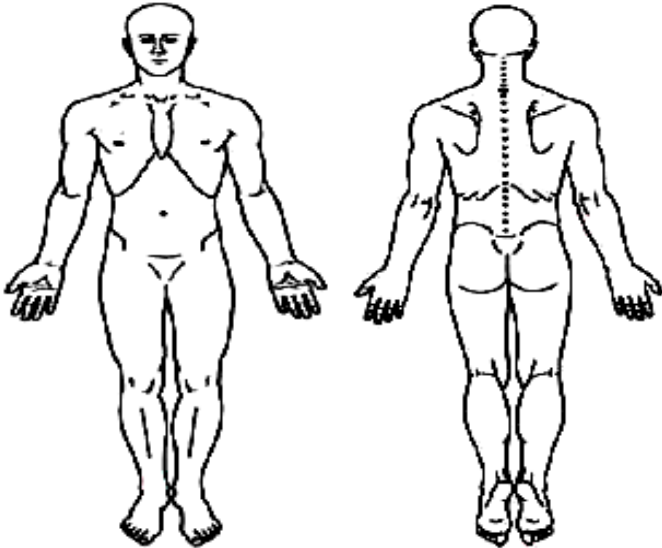
Grade Intensity/Severity: (Circle the number the best describes the pain)

(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

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 10. Recreation

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 8. Sleeping

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 4. Frequency of Pain

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 7. Personal Care (washing, dressing, etc)

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 3. Lifting

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 6. Travel(driving, etc)

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 2. Walking

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 5. Work

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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### 1. Standing

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No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain
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Name \_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Date