Hardin Chiropractic New Patient Intake Form

Patient Data **Date** ____

Title: (Circle one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

Full Name _____ **Nick Name**_____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____
By providing my email, I authorize my doctor to contact me via email provided.

Verification Question (choose one question by circling, then give at least a 6 character answer)

What is your favorite movie? In what city were you born? On what street did you grow up?

Verification Answer (6 or more characters) _____

Date of Birth _____/_____/_____ **Age**_____ **Sex:** □ Male □ Female Unspecified

Social Security Number: _____-_____-_____ **Marital Status:** □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Retired

Spouse Data ____

Spouse Full Name _____

Employer Data ____

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact ____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

How did you hear about our office? _____

Previous Chiropractic Care? YES NO List Physician _____

Physician's Signature: _____

Patient Name_____**Date**_____

Medical Conditions: (Circle all that apply to you)

□ Arthritis □ Cancer □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
Diabetes Type 1 (A1c>9.0%) Diabetes Type 2 (A1c>9.0%)
□ Other _____

Surgeries: (please list surgeries with year performed)

_____
□
_____

Fractures: : (please list fractures with year)

_____
□

Allergies: (Circle all that apply to you)

□ Eggs □ Fish and Shellfish □ Milk or Lactose □ Peanuts
□ Soy □ Sulfites □ Wheat/Glutens □ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never	
Drink Alcohol:	□ occasional	□ often	□ never	
Exercise:	□ occasional	□ often	□ never	
Chew Tobacco:	□ occasional	□ often	□ never	
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never	interested in quitting
Wear Seat Belts:	□ occasional	□ always	□ never	

Other _____

Family History: (Circle all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Occupational Activities: (Circle one that best describes your job description)

□ Administration □ Business Owner □ Clerical/Secretary □ Computer User
□ Heavy Equipment operator □ Daycare/Childcare □ Construction □ Health Care
□ Food Service Industry □ Medium Manual Labor □ Manufacturing □ Home Services
□ Heavy Manual Labor □ Light Manual Labor □ Executive/Legal □ Housekeeper
□ Other _____

To be performed by clinic staff:

Height:_____ Weight:_____ BP:_____ Pulse:_____ Temp_____ Resp._____

Physician's Signature: _____

Patient Name_____ **Date**_____

Review of Systems – (Check box if you have had trouble with any of the following, check NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

_____

Known drug allergies_____

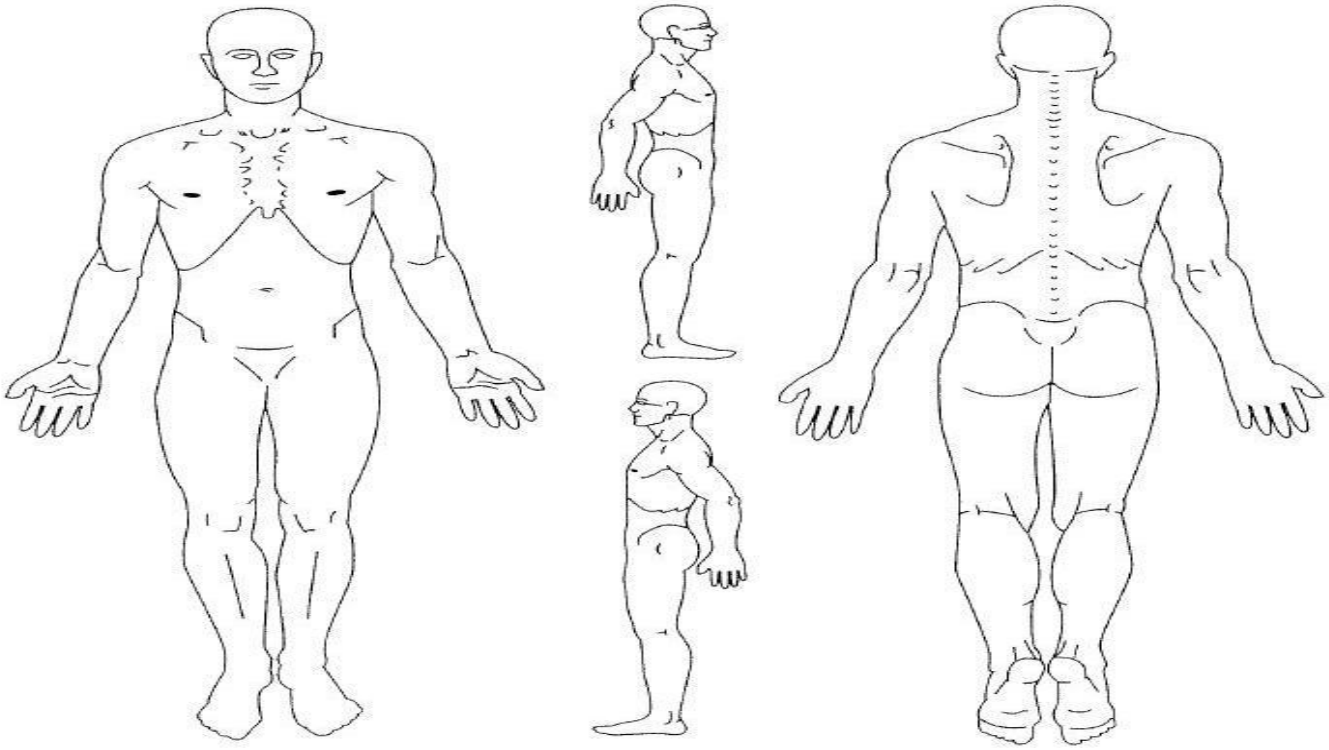
Are you pregnant? Yes_____ No _____N/A_____

Physician's Signature: _____

Patient Name_____ **Date**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

Current X-ray, CT Scan or MRI:_____

When did your current symptoms begin? _____

Are your symptoms a result of an accident: Motor Vehicle Work Related □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms? Constantly(76-100% of the day)□

Frequently(51-75% of the day)□ Occasionally(26-50% of the day) □ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp □ Dull ache □ Numb □ Shooting
□ Burning □ Tingling □ Stabbing □ Other _____

How are your symptoms changing?

□ Getting better □ Not changing □ Getting worse

Physician's Signature: _____

Patient Name_____Date_____

Payment/Insurance Information:

Payment is due at time of service. Cash, Check, MasterCard or VISA accepted.
We participate with some insurance companies. We file all insurance claims as a courtesy.

Who is responsible for your bill? □ Self Spouse Parent/Guardian Other_____

Please provide front desk with copy of Insurance Card and Valid Photo ID

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report? □Yes □No Date: ____/____/_____ Time: _____am / pm

Consent to Treat a Minor: I herby authorize Dr. Alice Hardin to administer treatment as she deems necessary

to (Print Minor's Name) _____

Parent/Guardian's Signature Authorizing Care _____

Print Parent/Guardian's Full Name_____

Date_____

Physician's Signature: _____ Date: _____