Spinal Center Clinics

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New Patient Intake

Today's Date: / /

PATIENT INFORMATION

Full Name (Last, First, MI): _____ Nickname: _____ Age: _____ Sex: ❑M ❑F

Date of Birth: _____/_____/_____ Social Security Number: _____

Street address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: (_____)_____Work Phone:(_____)_____ Cell Phone: (_____)_____Cell Provider:_____

Preferred Method of Contact: ❑Home ❑Work ❑Cell Email: _____

Marital Status? Choose ONE: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed # of Children: _____

Preferred Language: ❑ English ❑Spanish ❑Other_____

Would you like to receive appointment reminders? Choose ONE: ❑Email ❑Text Message ❑Phone Call ❑None

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Do you Drink? ❑Yes ❑No How much?_____ Please describe _____

Smoking Status: ❑Current everyday ❑Current some days: # Packs_____ ❑Former: Quit Date _____ ❑Never

How did you hear about our office? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____Work Activities: _____

Street address: _____City: _____ State: _____ Zip Code:_____

INSURANCE INFORMATION (If Auto Injury enter Auto Insurance Information)

Primary Insurance: _____ Policy or Claim Number: _____

Insured Name: _____ Ins. Date of Birth: ____/_____/_____

Relationship to Insured: ❑Spouse ❑Child ❑Self ❑_____

Address (if different): _____ City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____ Policy Number:_____

Insured Name: _____ Ins. Date of Birth: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

Health Information

Do you currently take any medications? ❑Yes ❑No If yes, Please list:

1.Drug Name: _____ Strength (e.g. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

2. Drug Name: _____ Strength (e.g. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

3. Drug Name: _____ Strength (e.g. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

Are you allergic to any Medication? ❑Yes ❑No If yes, Please list: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Are you currently pregnant? ❑Yes ❑No Due Date: _____/_____/_____ *** Do you have a pacemaker? ❑Yes** ❑No

Do you wear any other electrical devices? ❑Yes ❑No Please describe: _____

Please list **ALL** previous injuries or illness:

1. _____ Date: ____/____/_____
2. _____ Date: ____/____/_____
3. _____ Date: ____/_____/_____

Please list previous surgeries or operations:

1. _____ Date:___/____/____
2. _____ Date: ___/____/____
3. _____ Date: ___/____/____

Do you have any permanent impairment or disability? ❑Yes ❑No Percentage Rating: _____

Family Physician Name: _____ Phone: _____ Last Visit: _____

Have you ever been treated by a Chiropractor before? ❑Yes ❑No What were the results? _____

Please indicate which conditions **YOU or YOUR FAMILY** have experienced by marking the boxes below.

	Self	Mother	Father	Sister	Brother	Daughter	Son
Cancer							
Clotting Disorder							
Alzheimer's							
Dementia							
Diabetes							
Gastrointestinal Disorder							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Lung Disease							
Osteoporosis							
Psychological Disorder							
Septicemia							
Stroke							
SIDS							
HIV/ARC							
Unknown							

Name: _____ Date of Birth: _____/_____/_____

Pain Complaint

Please list your areas of pain:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

How long have you had it: _____ How did it start: _____

Is it: ❑Improving ❑ Worsening ❑Staying the Same Is it: ❑Mild ❑ Moderate ❑ Severe Is it worse in the: ❑ AM ❑PM

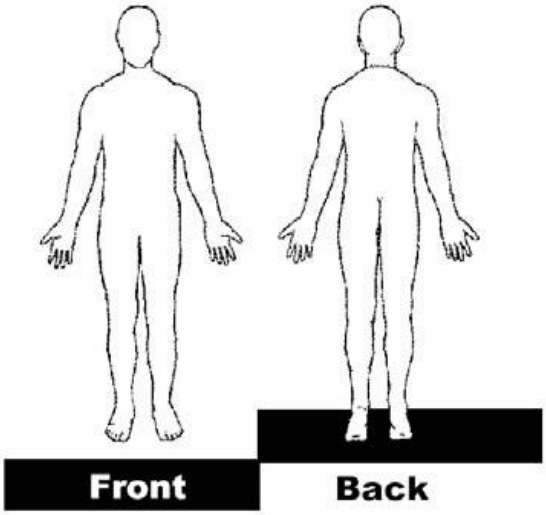
Is the symptom: ❑ Dull and Achy ❑ Tight and Stiff ❑ Sharp and Stabbing ❑ Numb and Tingly ❑ Shooting ❑Burning ❑ Cramping

What worsens it: ❑General activity ❑Moving Wrong ❑Bending ❑ Lifting ❑Walking ❑ Sports ❑Getting up from a chair ❑Using a computer/desk work ❑other: _____

What makes it better: ❑ Rest ❑ General Activity ❑ Ice Packs ❑ Heating Pad ❑ OTC Meds ❑ Rx Meds ❑ Massage ❑ Chiropractic ❑Other:_____

Are you able to? ❑ Bend and lift with no pain ❑ Get up from sitting with no pain ❑ Read with no pain ❑ Sleep with no pain ❑ Work at a computer with no pain ❑ Do your housework with no pain ❑ Do your yard work with no pain ❑ Play sporting activities with no pain

Please indicate your areas of pain on the diagram:



Consent for Treatment:

I hereby request and consent to the performance of chiropractic treatments and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment. I also give my consent to the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case. I also understand all X-rays remain the property of this clinic.

Patient signature: _____ Date: ____/_____/_____

(parent or guardian if under the age of 18)