



New Patient Intake Form

Patient Data

Date

Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

I prefer to be called by _____

Address Line _____

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

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

Cell Phone (____) _____ - _____ **Email** _____

Date of Birth ____/____/____ **Sex:** ☐ Male ☐ Female

Social Security Number: ____ - ____ - ____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

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

How did you hear about our office? _____

Patient Name _____

Date _____

Medical Conditions: (Check all that apply to you)

- ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
☐ Other _____

Surgeries: (Check all that apply to you)

- ☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical spine ☐ Hysterectomy
☐ Joint Replacement ☐ Prostate ☐ Lumbar spine ☐ Gall Bladder
☐ Brain ☐ Shoulder ☐ Thoracic spine ☐ Knee
☐ Carpal Tunnel ☐ Gastro-intestinal ☐ Uro-genital ☐ Hernia
☐ Other _____

Allergies: (List any allergies)

Social History: (Check all that apply to you)

- Caffeine use: ☐ occasional ☐ often ☐ never
 Drink Alcohol: ☐ occasional ☐ often ☐ never
 Exercise: ☐ occasional ☐ often ☐ never
 Tobacco Use: ☐ occasional ☐ often ☐ never
 Sleep: Hours per night= _____
 Stress Level: High Moderate Low None

Family History: (Check 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 _____

Patient Name _____

Date _____

Review of Systems – (Check if you have had trouble with any of the following within the last 3 months)

General:

- ☐ Weight change
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weakness
- ☐ Fatigue

Eyes:

- ☐ Vision
- ☐ Pain
- ☐ Discharge

Ears:

- ☐ Hearing
- ☐ Ringing
- ☐ Pain
- ☐ Discharge

Nose:

- ☐ Pain
- ☐ Bleeding
- ☐ Taste

Mouth/Throat:

- ☐ Sores
- ☐ Bleeding
- ☐ Taste

Skin:

- ☐ Rash
- ☐ Itching
- ☐ Hair Changes
- ☐ Nail Changes

Neurologic:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions

G-I:

- ☐ Appetite
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

G-U:

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Incontinence

Cardio:

- ☐ Murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Wheezing
- ☐ Blue Extremities
- ☐ Swollen Extremities

Breasts:

- ☐ Mass
- ☐ Pain
- ☐ Discharge
- ☐ Self-exam

Psychologic:

- ☐ Anxiety
- ☐ Depression
- ☐ Moods
- ☐ Memory

Musculoskeletal

- ☐ Neck
- ☐ Upper Extremities
- ☐ Upper Back
- ☐ Lower Extremities
- ☐ Lower Back

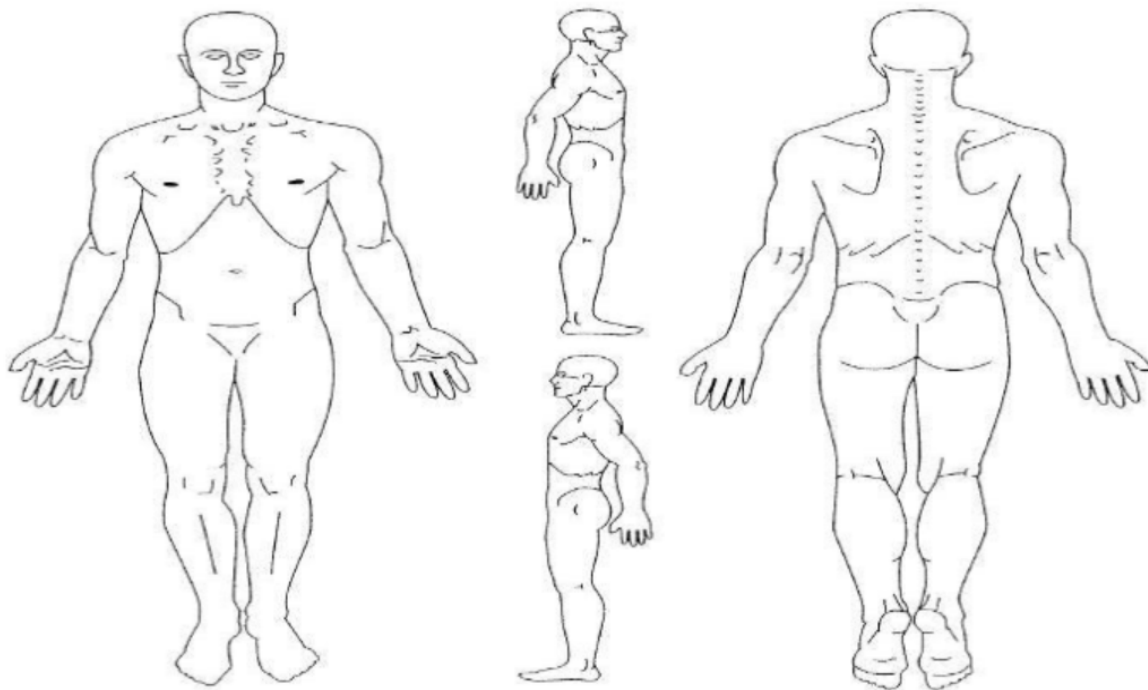
Additional Info:

Please list ALL current medications and/or supplements being taken:

Patient Name _____ **Date** _____

Are you pregnant? Yes _____ No _____ N/A _____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

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

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other _____

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

Patient Name _____ **Date** _____

Activities of Daily Living

Please circle if you have pain or difficulty performing the following:

Bending	Carrying Groceries	Change Posn–Sit–Stand	Climb Stairs
Driving			
Extended Computer Use	Feeding	Household Chores	Kneeling
Lift Children			
Lifting	Pet Care	Reading (Concentration)	Self Care–Bathing
Self Care–Dressing			
Sexual Activities	Sleep	Static Sitting	Static Standing
Walking			
Yard Work	Other _____		

What type of treatment are you looking for?

- ☐ I am looking for the most minimal amount of care to “patch up the symptoms” of my problem
- ☐ I am looking to resolve my symptoms and then go on to “fix the cause” of my problem
- ☐ I am looking to take care of my problem and then go on to “achieve optimal health and wellness”

Cancellation Policy

We are very pleased to participate in your healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy which follows:

Our office requires at least 24 hour notice for all appointment cancellations. If you are unable to provide 24 hour notice, you will be billed a \$25.00 charge to your credit card on file for scheduled chiropractic appointments.

Please circle one: Visa Discover MasterCard

Card Number: _____

Expiration Date: _____

Cardholder: _____

Signature: _____

Your credit card will not be charged without notification. It is kept on file only to enforce the cancellation policy.

Please sign stating you agree to the terms and conditions.

Signature _____ Date: _____



Patient Name _____ **Date** _____

Payment/Insurance Information:

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other _____

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 with your employer? ☐ Yes ☐ No Date: ____/____/____ Time: ____am / pm

If Work is responsible, Please fill out the following:

Employer Data _____

Name _____
Your Occupation _____ Your Job Description _____
Address _____
City _____ State _____ Zip Code _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date _____

SIGNATURE OF PHYSICIAN: _____ **Date:** _____

INFORMED CONSENT FORM

PATIENT NAME: _____ **DATE:** _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

One treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the chiropractic procedures.

The material risks inherent in chiropractic treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Symptoms may increase and over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [] or have read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Onya and have had many questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

**Signature of Parent or Guardian
(if a minor)**