NEW PATIENT INTAKE FORM

Patient File #: _____ **Today's Date: _____ /_____/_____**

PERSONAL INFORMATION:

Name: (*First*)_____ (*Middle Initial*)_____(*Last*)_____ Jr., II, III, IV

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

Birth Date: _____/_____/_____ Age: _____ Marital Status (*Circle*): Divorced Married Single Separated Widowed

Do you have children? □ Yes □ No If yes, # of children _____

Gender (*Circle*): Male / Female Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security #: _____-_____-_____ Email Address: _____

Employer /Employment Status □Employed □Unemployed □Full Time / □Part Time Student □Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (_____) _____-_____ Type of Work:_____

Is it ok to contact you at work? □ Yes □ No

Emergency Contact Information

Name: (*First*)_____ (*Middle Initial*)_____(*Last*)_____ Jr., II, III, IV

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

Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

□ Yes □ No

Who besides yourself is responsible for your bill?

□Self-Pay □Health Insurance □Medicare □Medicaid □ Worker's Comp □Auto Insurance

□ Other (*Be Specific*): _____

Auto or Workers' Comp Insurance Carrier & Claim #: _____

COMPLAINTS:	**WHEN DID IT START?**
1.	
2.	
3.	
4.	
5.	
6.	

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____

_____

_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____

_____

_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

_____

_____

_____

ASSOCIATED Complaints:

Ringing in Ears ☐Yes ☐No ☐Left ☐Right ☐Both Ears
Blurry Vision ☐Yes ☐No ☐Left ☐Right ☐Both Eyes
Nausea/vomiting ☐Yes ☐No
Headaches ☐Yes ☐No
☐ Depression ☐ Nervousness ☐ Fatigue ☐ Anxiety ☐ Excessive irritability
☐ Fear of driving in a car ☐ Loss of concentration ☐ Jaw clenching ☐ Dizziness
☐Nightmares

Numbness/Tingling:

☐ Left Hand ☐Left Upper Arm ☐Right Hand ☐Right Upper Arm
☐ Left Foot ☐Left Leg ☐Right Foot ☐Right Leg

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins. I understand and agree that this office has the right to terminate my care as a patient if I do not follow the prescribed treatment for my condition. I understand and agree that I might be referred to another health provider as the doctor deems medically necessary.

_____ _____

PATIENT PRINTED NAME **PATIENT SIGNATURE**

_____

DATE