UNIVERSITY CHIROPRACTIC

Patient Intake Form

Only fully completed forms will be accepted. Thank you!

PATIENT INFORMATION

Date:

Patient's Name:

Address:

City: **State:** **Zip:**

Sex: **Age:** **Birthdate:**

Social Security #:

Marital Status: Single Married Divorced Widowed

Occupation:

Employer:

Employer Address:

Employer Phone:

PHONE NUMBERS

Cell: **Home:**

Best time/number to reach you:

Emergency Contact Information:

Name: **Relation:**

Cell: **Work Phone:**

E-Mail Address:

To be used for appointment reminders, document requests, facility events, newsletters and birthday gifts.

Who may we thank for referring you?

ACCIDENT INFORMATION

Is this condition due to an accident? Yes No

If Yes, Date of Accident:

Type of accident: Auto Work Home Other

To Whom have you made a report of your accident?

Auto Insurance Employer Worker's Comp. Other

Attorney Name (if applicable):

INSURANCE

Who is the policy holder?

Relationship to policy holder?

Insurance Company:

Group #:

Supplemental Insurance? Yes No

Subscriber's Name:

Birthdate: **SS#:**

Relationship to policy holder?

Insurance Company:

Group #:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with University Chiropractic and assign directly to Dr. Smith and/or Dr. Start all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:

Relationship: **Date:**

Wellness Commitment:

At our office we are dedicated to achieving the goal of total lasting health for our patients. To achieve this goal we need to understand your commitment toward being healthy. Based on a scale of 10% to 100% please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10%------25%------50%------75%------100%

Health History & Medications

What treatment have you already received for your condition?			
Medications Surgery Physical Therapy None Other:_____			
Name & Address of other doctor(s) who have treated you for this condition:			
Date of Last:	Physical Exam _____	Spinal X-Ray _____	Blood Test _____
	Spinal Exam _____	Chest X-Ray _____	Urine Test _____
	Dental X-Ray _____	MRI, CT-Scan, Bone Scan _____	

Circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	**Diabetes**	Yes	No	**Measles**	Yes	No	**Rheumatoid Arthritis**	Yes	No
Alcoholism	Yes	No	**Emphysema**	Yes	No	**Migraines**	Yes	No	**Rheumatic Fever**	Yes	No
Allergy Shots	Yes	No	**Epilepsy**	Yes	No	**Headaches**	Yes	No	**Scarlet Fever**	Yes	No
Anemia	Yes	No	**Fractures**	Yes	No	**Miscarriage**	Yes	No	**Stroke**	Yes	No
Anorexia	Yes	No	**Glaucoma**	Yes	No	**Mononucleosis**	Yes	No	**Suicide Attempt**	Yes	No
Appendicitis	Yes	No	**Goiter**	Yes	No	**Multiple Sclerosis**	Yes	No	**Thyroid Problems**	Yes	No
Arthritis	Yes	No	**Gonorrhea**	Yes	No	**Mumps**	Yes	No	**Tonsillitis**	Yes	No
Asthma	Yes	No	**Gout**	Yes	No	**Osteoporosis**	Yes	No	**Tuberculosis**	Yes	No
Bleeding Disorders	Yes	No	**Heart Disease**	Yes	No	**Pacemaker**	Yes	No	**Tumors, Growths**	Yes	No
Breast Lump	Yes	No	**Hepatitis**	Yes	No	**Parkinson's**	Yes	No	**Typhoid Fever**	Yes	No
Bronchitis	Yes	No	**Hernia**	Yes	No	**Pinched Nerve**	Yes	No	**Ulcers**	Yes	No
Bulimia	Yes	No	**Herniated Disk**	Yes	No	**Pneumonia**	Yes	No	**Vaginal Infections**	Yes	No
Cancer	Yes	No	**Herpes**	Yes	No	**Polio**	Yes	No	**Venereal Disease**	Yes	No
Cataracts	Yes	No	**High Cholesterol**	Yes	No	**Prostate Problem**	Yes	No	**Whooping Cough**	Yes	No
Chemical Dependency	Yes	No	**Kidney Disease**	Yes	No	**Prosthesis**	Yes	No	**Other:**		
Chicken Pox	Yes	No	**Liver Disease**	Yes	No	**Psychiatric Care**	Yes	No			

EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/Day_____
Moderate	Standing	Alcohol	Drinks/Week_____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day_____
Heavy	Heavy Labor	High Stress Level	Reason_____

Are you pregnant? Yes No **Due Date:**_____

Injuries/Surgeries you have had:	**Description**	**Date(s)**
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

PATIENT CONDITION(S)

Please answer the following questions to the best of your ability:

Are you currently experiencing any of the following?

Neck Pain If YES, is it (circle):	Dull Achy Tingling Numb Sharp Burning Radiating
Mark what % of the time you experience your pain.	[0%------25%------50%------75%-------100%]
Pain Scale (0 = no pain and 10 = unbearable pain)	0 1 2 3 4 5 6 7 8 9 10
Onset Date:	
Probable cause of your symptoms?	

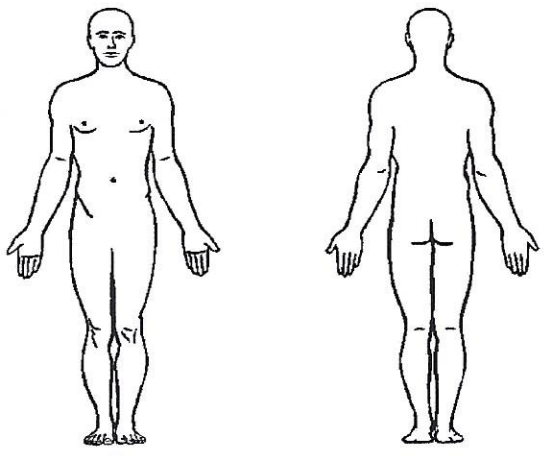
Headaches/Migraines If YES, is it (circle):	Dull Achy Tingling Numb Sharp Burning Radiating
Mark what % of the time you experience your pain.	[0%------25%------50%------75%-------100%]
Pain Scale (0 = no pain and 10 = unbearable pain)	0 1 2 3 4 5 6 7 8 9 10
Onset Date:	
Probable cause of your symptoms:	

Mid Back Pain If YES, is it (circle):	Dull Achy Tingling Numb Sharp Burning Radiating
Mark what % of the time you experience your pain.	[0%------25%------50%------75%-------100%]
Pain Scale (0 = no pain and 10 = unbearable pain)	0 1 2 3 4 5 6 7 8 9 10
Onset Date:	
Probable cause of your symptoms:	

Low Back Pain If YES, is it (circle):	Dull Achy Tingling Numb Sharp Burning Radiating
Mark what % of the time you experience your pain.	[0%------25%------50%------75%-------100%]
Pain Scale (0 = no pain and 10 = unbearable pain)	0 1 2 3 4 5 6 7 8 9 10
Onset Date:	
Probable cause of your symptoms:	

Other:_____ If YES, is it (circle):	Dull Achy Tingling Numb Sharp Burning Radiating
Mark what % of the time you experience your pain.	[0%------25%------50%------75%-------100%]
Pain Scale (0 = no pain and 10 = unbearable pain)	0 1 2 3 4 5 6 7 8 9 10
Onset Date:	
Probable cause of your symptoms:	

Please indicate the location of your complaints with an "x"



Comments:_____

_____

_____

_____

_____