NEW PATIENT INTAKE FORM

Patient Information:

Please complete this form in ink. If you have any questions do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ____ Date____________ Patient No. ____________S/S_____ - _____ - _____

First MI Last

Address ____ City __________________ State ________ Zip__________

Email address: ____

Birth Date_________________________ Home Phone # _________________________ Work Phone # _________________________

Your current Primary Medical Doctor_____________________ City_____________ May we contact them?

❒ No ❒ Yes

Are you: ❒ Minor ❒ Married ❒ Divorced ❒ Widowed ❒ Single ❒ Separated

Your Employer ____ Occupation____

Business Address ____ City __________________ State__________ Zip ________

Spouse's or Parent's Name _________________________ Workplace __________________ Work Phone# _____________________

Whom may we thank for referring you to us?

____

Person to contact in case of emergency ____ Phone # _____________________

Insurance Information

Do you currently have insurance? ❒ No ❒ Yes. IF NO for your convenience we accept cash, check, visa, mastercard &discover

Insurance Company Name__________________________________(please note we do not accept all insurances)

Insurance Card Number____

Do you have a deductible? _________________________

Symptoms

Reason for Surgery ____ When did you first notice the symptoms? __________

Is this injury the result of a work related incident or automobile accident? ____

Is this condition getting progressively worse? ____

Where specifically is the problem(s) located? ____

Which activities are difficult to perform? ❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down

Type of Pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting
❒ Burning ❒ Tingling ❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other _____________

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ____

What other treatment have you already received for your condition? ❒ Medication ❒ Physical Therapy

(Women) Are you pregnant? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

List any types of surgeries which you have had and the dates which they occurred: ____

____

Please list all medications you are currently taking: ____

Allergies:____

Daily Habits

What type of exercise do you perform on a daily basis? ❒ None ❒ Moderate ❒ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work, etc.) ____

Do your currently wear orthotics? ____

Do you smoke? ❒ Yes ❒ No How much per day? ____

How much coffee or caffeinated beverages do you consume on a daily basis? ___________________________________

Health History

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS
- ☐ Recent accident such as a fall, whiplash, or blow to the head
- ☐ Spinal/back/neck problems
- ☐ Muscle spasms
- ☐ Restricted movement
- ☐ Tingling or numbness of arms, legs, hands or feet
- ☐ Headaches or migraines more than once per month
- ☐ Sinus problems
- ☐ Depression or Anxiety
- ☐ Difficulty dealing with stress
- ☐ Dizziness or vertigo
- ☐ Vision or Hearing problem
- ☐ Sleeping trouble
- ☐ Breathing trouble or Asthma
- ☐ Digestive trouble or Nausea
- ☐ Heartburn/Acid Reflux
- ☐ Menstrual problems
- ☐ Jaw or mouth problem
- ☐ Arm, shoulder, elbow or hand problem (circle)
- ☐ Leg, hip, knee or foot problem (circle)

DIAGNOSED CURRENT CONDITIONS
- ☐ Born with bone or joint disorder
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Compression fracture
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ☐ 3 or more months of steroid medications or intravenous drugs (past or present)
- ☐ Tuberculosis, Hepatitis or HIV
- ☐ Multiple sclerosis
- ☐ Thyroid or hormone disorder
- ☐ High blood pressure
- ☐ Convulsions/epilepsy
- ☐ Allergies:______________________
- ☐ OTHER:

CURRENT OTHER ISSUES
- ☐ Difficulty swallowing because of neck pain
- ☐ Pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain worse with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that doesn’t improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS
- ☐ Poor balance
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent, unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F

Our Privacy Policy

The surgery center is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with surgery center. may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare. Members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone/email and you are not at home a message will be left on your answering machine.

Assignment of Insurance Payments

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Waldman Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

By signing below, I have read, or have had read to me, and agree to the above Privacy Policy Assignment of Insurance Payments, and that I certify that my confidential medical information presented is correct to the best of my knowledge.

Patient or Guardian’s Signature____ **Date** ______________

Patient’s Name (PRINTED)________________________________