New Patient Intake Form

Name_____ Today's Date _____/_____/_____

Address_____

City_____ State_____ Zip Code_____

E-Mail _____ Who Referred you to our office:_____

Cell Phone _____ Home Phone _____ Work Phone _____

Age_____ Birth Date____/_____/_____ Marital: M S W D How many Children?_____

Occupation (if dependent list parent's occupation)_____

Employer_____ Address _____

Name of Spouse _____ Occupation _____

Employer _____ Office Phone _____ Other Phone _____

Emergency Contact _____Phone _____ Other Phone _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT! □ Cash □ Check □ Visa/MC

Person responsible for payment

Name_____ Phone _____ Other _____

Address_____ City _____ Zip _____

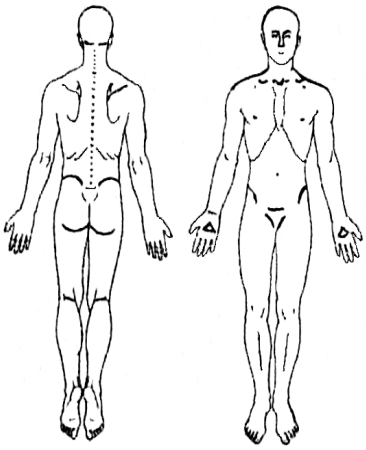
Are you Insured? □ YES □ NO Insurance Company _____

Other Doctors seen for this Condition_____

Have you been treated for any health condition by a physician in the last year? □ YES □ NO

Describe_____

List all current Medications:_____



Confidential Health History

Please outline on the diagram the area of your discomfort.

Please describe your present complaints and rate them on a scale of zero to 10

_____

_____

_____

_____

_____

_____

Is this a work related injury? □YES □NO Is the condition: □ Worsening □ Improving □ Staying the same

When did your present complaints occur? _____

Activities/Body Functions affected (i.e. walking, sitting, working, etc.) _____

_____

Is this condition interfering with your □ Work □ Sleep □ Recreation Dates missed: _____

Have you had this condition or similar conditions in the past? □ YES □ NO If so, when? _____

What treatment did you receive? _____

What type of care are you interested in: □ Temporary Relief □ Lasting Correction □ Best Care Possible

Name & location of previous chiropractor: _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken bones: _____ Knocked unconscious: _____

Surgeries: _____

Please check any of the following that apply to your current/past medical history:

- o Allergy
- o Asthma
- o Shoulder pain
- o Heartburn
- o Hay fever
- o Hiatal hernia
- o Migraines
- o Sore throats
- o Loss of weight
- o Shortness of breath
- o Hardening of arteries
- o Liver trouble
- o Hyperactivity
- o Numbness in legs or feet
- o Stroke
- o Swollen ankles
- o Stomach ulcers
- o Foot trouble
- o Frequent urination
- o Kidney stone
- o Kidney infection
- o Bladder infection
- o Painful urination
- o Poor urine control
- o Blood in urine
- o Prostate trouble
- o Swollen joints
- o Belching or gas
- o Fainting
- o Colon trouble
- o Headaches
- o Nosebleeds
- o Tuberculosis
- o Difficulty breathing
- o Jaundice
- o Polio
- o Bursitis
- o Poor circulation
- o Sprained ankle
- o Vomiting of blood
- o Bed-wetting
- o Low backache
- o Painful tailbone
- o Sciatica
- o Spinal curvature
- o Stiff or painful neck
- o Leg pain
- o Pain between shoulders
- o Arm Pain
- o Knee Pain
- o Thyroid trouble
- o Diabetes
- o Enlarged Glands
- o Gout
- o Nasal congestion
- o Itching
- o Chronic cough
- o Heart disease
- o Hemorrhoids
- o Cancer
- o Arthritis
- o Chest pain
- o Vomiting
- o Broken bones
- o Weakness in legs
- o Rheumatic fever
- o Sinus infection
- o Convulsions
- o Stomach aches
- o Dentures
- o Bruise easily
- o Diarrhea
- o Varicose veins
- o Gall bladder trouble
- o Depression
- o Emphysema
- o Low blood pressure
- o Poor appetite
- o Surgery
- o Weakness in arms
- o Slow heart beat
- o Bad posture
- o Anemia
- o Poor hearing
- o Burning sensations
- o Fatigue
- o Eczema/Hives
- o Constipation
- o Loss of sleep
- o Excessive hunger
- o Nervousness
- o Spitting up blood
- o High blood pressure
- o Nausea
- o Tumor
- o Numbness in arms/hands
- o Rapid heart beat
- o Difficulty swallowing
- o Heart attack
- o Ringing in ears
- o Angina

For Women Only:

- o Premenstrual tension
- o Menopausal symptoms
- o Excessive flow
- o Tubal ligation
- o Vaginal discharge
- o Unable to get pregnant
- o Menstrual cramps
- o Hysterectomy
- o Lumps in breast
- o Irregular cycle

Is there a possibility that you may be pregnant? ☐ YES ☐ NO

Date of last menstrual period _____

Family Health History:

Heart Problems: Type _____ Family Member(s) _____

Cancer: Type _____ Family Member(s) _____

Diabetes: Type _____ Family Member(s) _____

Arthritis/neck/back pain: Type _____ Family Member(s) _____

Allergies/Asthma/Autoimmune: Type _____ Family Member(s) _____

Other (liver,kidney,stomach,etc.): Type _____ Family Member(s) _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Broadway Chiropractic Office, PLLC 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 Broadway Chiropractic Office, PLLC will be to my account on the receipt. However, I clearly understand and agree that all services rendered to 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.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____