CHIROPRACTIC CENTER
BISCAYNE

# PATIENT INTAKE FORM

TODAY'S DATE _____

## PATIENT INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Sex: ☐ M ☐ F SS #: _____-_____-_____ Age: _____ Date of Birth: ___/___/___

First Name: _____ Middle Initial: _____ Last Name: _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail _____ May we contact you via email: ☐ Yes ☐ No

Have you received chiropractic care in the past? ☐ Yes ☐ No How did you hear about our office? _____

## SPOUSE/PARTNER

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Children: ☐ No ☐ Yes How Many: _____

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: ____/____/____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

## EMERGENCY CONTACT (if different from above)

Name _____ Relationship _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Nearest Relative **(if different from above)** _____

Relationship _____ Phone _____

## EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____ Office Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

## PURPOSE OF THIS APPOINTMENT

Is the condition due to injury or sickness arising out of auto or other accident? ☐ Yes ☐ No Employment? ☐ Yes ☐ No

Explain: _____

Days lost from work? _____ Date symptoms appeared or accident happened ___/___/___

Other doctors seen for this condition _____

## PAST, FAMILY, AND SOCIAL HISTORY

Have you been treated for any health conditions by a physician in the past 6 months)? ☐ Yes ☐ No

If yes, when and describe _____

_____

Have you ever had the same or similar condition? ☐ Yes ☐ No

If yes, when and describe _____

_____

## MEDICAL HISTORY

What medications or drugs are you taking (past 6 months)? _____

_____

Medical Doctor _____ Date of last physical exam ____/____/_____

What operations have you had? _____ When? ____/____/_____

Serious Illnesses? _____ When? ____/____/_____

Allergies? ☐ No ☐ Yes _____

How often do you exercise? ☐ Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Never

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine How often per day? _____

Has anyone in your family had any of the following problems? ☐ Arthritis ☐ Cholesterol ☐ Heart Problems ☐ Psychiatric Problems ☐ Thyroid ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Other:_____

## REVIEW OF SYSTEMS - Have You Ever Had Any Of The Following?

**Cardiovascular**
☐ Poor Circulation
☐ High Blood Pressure
☐ Aortic Aneurysm
☐ Heart Disease
☐ Vascular Disease
☐ Heart Attack
☐ Chest Pain
☐ High Cholesterol
☐ Pace Maker

**Neurological**
☐ Stroke
☐ Seizures
☐ Head Injury
☐ Brain Aneurysm
☐ Numbness
☐ Pinched Nerves
☐ Carpal Tunnel
☐ Balance Problems

**Hematologic/Lymphatic**
☐ Hepatitis
☐ Blood Clots
☐ Cancer
☐ Easy Bruising
☐ Easy Bleeding
☐ Fevers/Chills/Sweats

**Musculoskeletal**
☐ Gout
☐ Arthritis
☐ Joint Stiffness
☐ Muscle Weakness
☐ Osteoporosis
☐ Broken Bones
☐ Joints Replaced

**Psychiatric**
☐ Depression
☐ Anxiety Disorder
☐ Unusual Stress

**Allergic/Immunologic**
☐ Hives
☐ Immune Disorder
☐ HIV/AIDS
☐ Allergy Shots
☐ Cortisone Use

**Genitourinary**
☐ Kidney Disease
☐ Lower Side Pain
☐ Burning Urination
☐ Frequent Urination
☐ Blood in Urine
☐ Kidney Stones

**Eyes**
☐ Glaucoma
☐ Double Vision
☐ Blurred Vision

**Respiratory**
☐ Asthma
☐ Tuberculosis
☐ Shortness of Breath
☐ Emphysema
☐ Cold/Flu
☐ Cough/Wheezing
☐ Sputum
☐ Coughing Blood

**Ears/Nose/Throat**
☐ Hearing Loss
☐ Sinus Infection
☐ Nosebleed
☐ Sore Throat
☐ Swallowing
☐ Bleeding Gums

**Head**
☐ Headaches
☐ Severe Headaches
☐ Migraines
☐ Head Injury

**Gastrointestinal**
☐ Gallbladder
☐ Bowel Problems
☐ Constipation
☐ Liver Problems
☐ Ulcers
☐ Diarrhea
☐ Nausea/Vomiting
☐ Bloody Stools

**General**
☐ Weight Loss
☐ Weight Gain
☐ Energy Level
☐ Difficulty Sleeping

**Skin**
☐ Skin Lesions
☐ Skin Ulcers
☐ Skin Disease/Cancer
☐ Eczema
☐ Psoriasis

**Females:** Are you or could you be pregnant?
☐ Yes ☐ No Due Date: _____

**Other problems not elsewhere listed:**

## PAYMENT/INSURANCE INFORMATION - Payment is expected at time of visit.

Do you have health insurance: ☐ No ☐ Yes Company _____ Insurance phone number: _____

Person responsible for payment _____ Relationship _____

ID # _____ SS # _____-_____-_____ Cardholders Birth Date ____/____/____

**I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this 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 Chiropractic 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. I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. In addition, I have read and agree to all the above Financial Policies and Notices.**

Patient's Name (Printed) _____ Signature: _____ Date ___/___/___

Guardian's Signature: _____ Date ___/___/___