# New Patient Intake Form

## Patient Information

**Full Name** _____ **Nickname** _____ **Date** _____
First MI Last

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Age** _____ **Date of Birth** _____ **Sex** □ Male □ Female **Marital Status** □ Single □ Married □ Other

**SS #** _____ **Email** _____ **I prefer to receive calls at** □ Home □ Work □Cell

**Home Phone** _____ **Work Phone** _____ **Cell Phone** _____ Cell Provider_____

**Employer** _____ **Occupation** _____

**Spouse Name** _____ **Spouse Cell Phone** _____

Primary Language Spoken_____ Race_____ Ethnicity_____

**Emergency Contact** _____ **Relationship** _____ **Contact Phone** _____

**How did you hear about us? □Location □Internet □Marketing Ad □Patient Referral (_____) □Other** _____
Name

## Payment Information

**Person Responsible for Payment** _____ **Date of Birth** _____ **Phone** _____

**SS#** _____ **Do you have health insurance?** □ Yes □ No **Are you the Policy Holder?** □ Yes □ No

## Insurance Information

| Primary Insurance | Secondary Insurance |
|---|---|
| Insurance Company | Insurance Company |
| Policy Holder's Name | Policy Holders Name |
| Relationship to Patient | Relationship to Patient |
| Policy Holder's Birth Date | Policy Holder's Birth Date |
| Group Number | Group Number |
| Policy ID Number | Policy ID Number |

*Please have your insurance card and driver's license ready so they can be copied for the clinic's records.*

## Consent for Treatment

***Assignment & Release- By signing below, I authorize Kinetic Spine & Sports to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Kinetic Spine & Sports and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations.***

*By signing below, I give my consent for examination and the performances any testes or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.*

**Patient/Guardian Signature** _____ **Date** _____

# Health Questionnaire

## Patient Information

**Full Name** _____ **Date of Birth** _____ **Height** _____ **Weight** _____

## Medical History

**Describe the reason for your visit** _____

**When did your symptoms begin?** _____ **How did your symptoms begin?** _____

**How often do you experience your symptoms?** □ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**Describe your symptoms?** □ Sharp □ Dull ache □ Numb □ Shooting □ Burning □Tingling □ Stabbing

**How are your symptoms changing?** □ Getting better □ Staying the same □ Getting worse

**Are your symptoms affecting your daily activities**? □ Severe (Unable to Perform) □ Moderate (Painful/Limited) □ Mild (Painful/Can Do) □ No Effect (Discomfort)

**On a scale of one to ten how intense are your symptoms?** **(**Not intense) 0 1 2 3 4 5 6 7 8 9 10 (Unberable)

## History of Treatment

**Primary Care Physician** _____ **Facility** _____ **Phone** _____

**Have you seen a Chiropractor before?** □ Yes □ No **If yes, when was your last visit?** _____

**Have you seen another doctor for these symptoms? If yes, who?** _____

**List all prescription, non prescription medications and other supplements you take as well as the associated condition**

_____

**List any surgeries or hospitalizations you have had complete with the month and year for each** _____

_____

**List any allergies** _____

**Family History (list all major diseases such as cancer, diabetes, heart problems, etc and the relation to you and the individual)**

_____

_____

**Do you smoke?** □ Yes □ No **If yes, how many packs per day?** _____ **Are you pregnant?** □ Yes □ No

## Description of Condition

**Using the key below, mark on the body diagram where you are experiencing the following symptoms:**

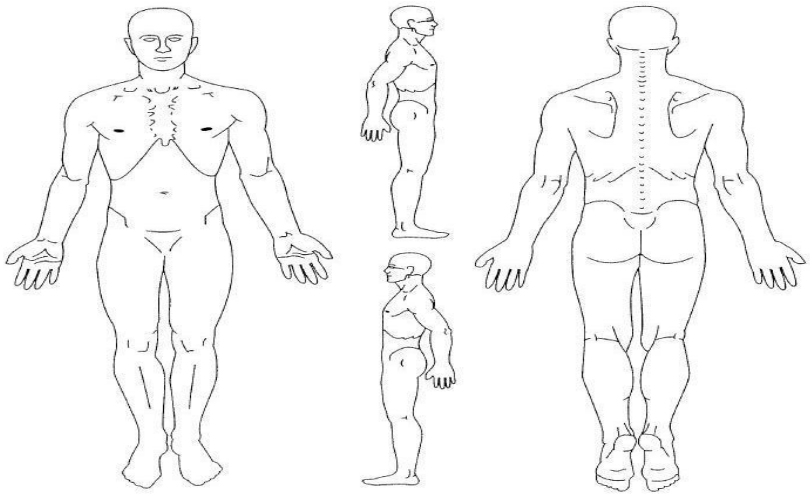
**N=Numbness**

**B=Burning**

**S=Stabbing**

**T=Tingling**

**A=Dull Ache**



## Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

| **Cardiovascular** | Past | Present | | **Respiratory** | Past | Present | | **Allergic/Immunologic** | Past | Present |
|---|---|---|---|---|---|---|---|---|---|---|
| Poor Circulation | | | | Asthma | | | | Hives | | |
| Hypertension | | | | Tuberculosis | | | | Immune Disorder | | |
| Aortic Aneurism | | | | Short Breath | | | | HIV/AIDS | | |
| Heart Disease | | | | Emphysema | | | | Allergy Shots | | |
| Heart Attack | | | | Cold/Flu | | | | Cortisone Use | | |
| Chest Pain | | | | Cough | | | | | | |
| High Cholesterol | | | | Wheezing | | | | | | |
| Pace Maker | | | | | | | | **Ear, Nose and Throat** | Past | Present |
| Jaw Pain /TMJ | | | | **Eyes** | Past | Present | | Difficulty Swallowing | | |
| Irregular Heartbeat | | | | Glaucoma | | | | Dizziness | | |
| Swelling of legs | | | | Double Vision | | | | Hearing Loss | | |
| | | | | Blurred Vision | | | | Sore Throat | | |
| **Genitourinary** | Past | Present | | | | | | Nosebleeds | | |
| Kidney Disease | | | | **Psychiatric** | Past | Present | | Bleeding Gums | | |
| Burning Urination | | | | Depression | | | | Sinus Infections | | |
| Frequent Urination | | | | Anxiety | | | | | | |
| Blood in Urine | | | | Stress | | | | **Gastrointestinal** | Past | Present |
| Kidney Stones | | | | | | | | Gall Bladder Problems | | |
| Lower Side Pain | | | | **Endocrine** | Past | Present | | Bowel Problems | | |
| | | | | Thyroid | | | | Constipation | | |
| **Neurologic** | Past | Present | | Diabetes | | | | Liver Problems | | |
| Stroke | | | | Hair Loss | | | | Ulcers | | |
| Seizures | | | | Menopausal | | | | Diarrhea | | |
| Head Injury | | | | Menstrual | | | | Nausea/Vomiting | | |
| Brain Aneurysm | | | | | | | | Bloody Stools | | |
| Numbness | | | | **Hematologic** | Past | Present | | Poor Appetite | | |
| Severe Headaches | | | | Hepatitis | | | | | | |
| Pinched Nerves | | | | Blood Clots | | | | **Musculoskeletal** | Past | Present |
| Parkinson's | | | | Cancer | | | | Gout | | |
| Carpal Tunnel | | | | Bruising | | | | Arthritis | | |
| Vertigo | | | | Bleeding | | | | Joint Stiffness | | |
| | | | | Fever, Chills | | | | Muscle Weakness | | |
| **Constitutional** | Past | Present | | Sweating | | | | Osteoporosis | | |
| Difficulty Sleeping | | | | | | | | Broken Bones | | |
| Weight Loss/Gain | | | | | | | | Joints Replaced | | |