New Patient Intake Form

Date _____

Name_____ Address_____

City_____ State_____ Zip Code_____ SS.#_____

E-Mail _____ Referred By_____

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_____

_____

Confidential Health History

Please outline on the diagram the area of your discomfort.

Please describe your present complaints

_____

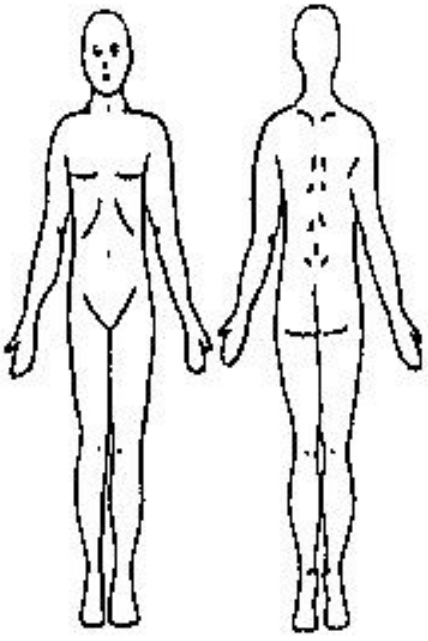
_____

_____

_____

_____

_____



Is this a work related injury? ___YES ___ NO

When did your present complaints occur? _____

Who has treated you for this condition (if anyone)? _____

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? _____

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:_____ Health problems of parents: _____

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_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Kaplowitz Chiropractic 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 Kaplowitz Chiropractic Clinic 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_____