Porters Neck Chiropractic New Patient Intake Form

Patient Data **Date** ____

First Name ____________________ **Middle Initial** ____ **Last Name** ___________________________

Nickname ___________________________ **Marital Status:** ☐ Single ☐ Married ☐ Other

Sex: ☐ Male ☐ Female **Social Security #:** _____-____-_____ **Date of Birth** ____/______/_______

Mailing Address ____

City ________________________________ **State** ___________________ **Zip Code** ______________

Local Address (If Different from mailing) ____

City ________________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-___________ **Work Phone (_____)** _________-_____________

Cell Phone (_____) ________-___________ **Email** ____________________________________

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data

Employer's Name ____

Your Occupation __________________________ **Your Job Description** ______________________

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Other ___________________________

If your injury was work related, have you filed an injury report with your employer? ☐Yes ☐No
Date: ____/____/____ Time: ______am / pm

Spouse/Parent Data ____

First Name ____________________ **Middle Initial** _____ **Last Name** __________________________

Employer's Name ____

Work Phone (_____) _______-__________ **Date of Birth** ____/______/_______

Doctor's Signature ___________________________________

Patient Name____Date__________________

Emergency Contact____

Contact Name ____________________________ Relationship to Patient ___________________

Contact Home Phone (_____) _______-________ Cell Phone (_____) ________-______________

How did you hear about our office? ____

Consent to Care

I hereby request and consent to chiropractic adjustments and other procedures including various modes of physical therapy, diagnostic x-rays and/or tests recommended by Porters Neck Chiropractic and their staff. I understand that results are not guaranteed and I am informed of the advantages and possible complications, if any, to treatment. I wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest.

Initials________

I understand that acupuncture is an integral part of treatment at Porters Neck Chiropractic. I hereby give my consent to have acupuncture if it is recommended by my doctor.

Initials________

Consent to treat if patient is a minor: (Minor's Printed Name) ___________________________________

I hereby certify that I have read and fully understand the above authorization for chiropractic treatments and by signing below I agree to the above terms and procedures.

Patient or Guardian's Signature Authorizing Care ____

Date_____________

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Porters Neck Chiropractic's Notice of HIPAA Privacy Practices for protected health information. I hereby give consent to Porters Neck Chiropractic, Inc. and all health care providers furnishing care within Porters Neck Chiropractic's facilities to use and disclose my protected information for the purposes of treatment, payment and health care operations.

Print Patient's Name ____

Patient's (Guardian's) Signature ____Date_________________

Doctor's Signature _________________________________

Patient Name____Date___________________

Financial Policy & Assignment of Benefits

Primary Health Insurance:__________________________ Card ID # ___________________________

Policy Holder's Name: ________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Relationship to Insured __________________

Secondary Health Insurance: ________________________ Card ID # ___________________________

Policy Holder's Name: _________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Relationship to Insured __________________

I hereby assign payment to Porters Neck Chiropractic, Inc or any physician rendering services and instruct my insurance company to make payment to this office directly for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I authorize Porters Neck Chiropractic Inc and any physician rendering service to release medical records or other information which may be necessary for completion of insurance claims. I understand that I am financially responsible for all charges not paid by my insurance company. Porters Neck Chiropractic, Inc files health insurance claims, but cannot guarantee insurance payments. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

There will be a $20 charge for missed appointments unless a cancellation notice is received 24 hours in advance of the appointment time.

I understand and agree that I am personally responsible for payment of this charge should I fail to comply with this policy and that this charge in no way will be billed to my insurance company.

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 intend this to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic.

_____________________________________ ___________________

Signature of Policyholder or Claimant Date

Doctor's Signature _________________________________

Patient Name ____ **Date** ____________________

<u>Medical Conditions</u>: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _______________			

<u>Surgeries</u>: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Other ____			

<u>Allergies</u>: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other __________

<u>Social History</u>: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never
Other _________________			

<u>Family History</u>: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling	Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling	Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling	Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling	Other ______________________________		

Doctor's Signature ____________________________________

Patient Name ____ **Date** ____________________

<u>Review of Systems</u> – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			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**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

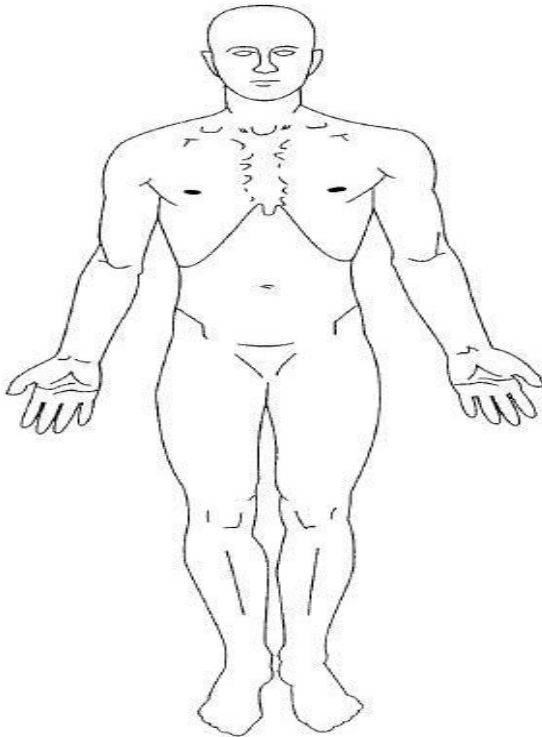
Please list all current medications being taken ____

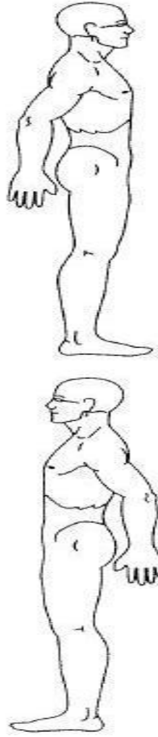
Doctor's Signature ________________________________

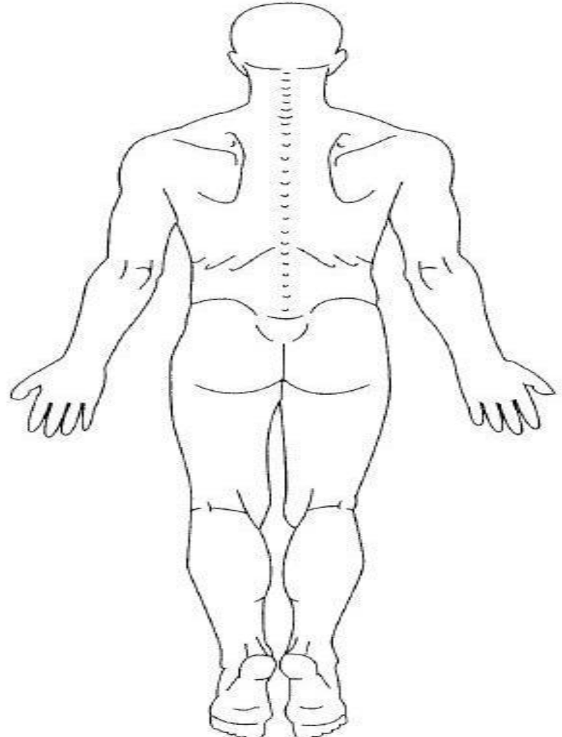
Patient Name____Date__________________

Are you pregnant? Yes_____ No ______N/A______

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache







Describe your symptoms in order of severity, with worse symptom being #1: ___________________
____
____
____

When & how did your symptoms begin? ____
____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other____

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)

How are your symptoms changing?
☐ Getting better ☐ Not changing ☐ Getting worse

SIGNATURE OF PHYSICIAN: _______________________________**Date:** ___________________

Patient Name____**Date**___________________

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used ____ **Score** ____________________

Description of Work: ____

Condition's Effect On Job Performance*:* ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability)
☐ **Mod/Sev (l**imited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Activity				
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

Activity				
___________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
___________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
___________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Doctor's Signature _________________________________

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