**NEW PATIENT INTAKE**

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date\_\_\_\_/\_\_\_\_/\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_-\_\_\_\_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_-\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently pregnant\_\_\_\_\_\_\_\_\_

Do you have health insurance? Yes\_\_\_\_ No\_\_\_\_ Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan/Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Medicare? \_\_\_\_\_\_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children\_\_\_\_\_\_\_\_

Names and ages of Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main reason for consulting our office today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please check if you are here for any of the following: \_\_\_\_Car Accident \_\_\_\_Work Injury \_\_\_\_Other

I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all the services covered or non-covered. 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 also give permission for Coron Family Chiropractic to render services to a minor without a guardian present.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females only:**

I certify that to the best of my knowledge I am **not** pregnant, and Coron Family Chiropractic has my permission to perform an X-ray evaluation if needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Female Patient’s Signature Date

**YOUR HEALTH PROFILE**

**Childhood Years (Age 0-17 years)** – Please check those items that apply to you:

\_\_\_\_\_ Recurrent Childhood Illness \_\_\_\_\_ Serious Falls \_\_\_\_\_ Active in Sports

\_\_\_\_\_ Alcohol/ Drug Abuse \_\_\_\_\_ Surgery/Stitches \_\_\_\_\_ Car Accident(s)

\_\_\_\_\_ Smoker \_\_\_\_\_ Antibiotics/Other Meds \_\_\_\_\_ Vaccinated

\_\_\_\_\_ Under Chiropractic Care \_\_\_\_\_ Severe Emotional Stress \_\_\_\_\_ Broken Bones

\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adult Years (Age 18 to Present)** – Please check those items that apply to you:

\_\_\_\_\_ Present Smoker \_\_\_\_\_ Former Smoker \_\_\_\_\_ Alcohol Abuse

\_\_\_\_\_ OTC/Prescription Meds \_\_\_\_\_ Surgery/Stitches \_\_\_\_\_ Play Sports

\_\_\_\_\_ Car Accident(s) \_\_\_\_\_ Work Injury \_\_\_\_\_ High-Stress Job

\_\_\_\_\_ High Personal Stress \_\_\_\_\_ Sit A Lot \_\_\_\_\_ Drive A Lot

\_\_\_\_\_ Poor/Inadequate Diet \_\_\_\_\_ Poor Sleep \_\_\_\_\_ Not Enough Sleep

\_\_\_\_\_ No Exercise \_\_\_\_\_ Wear Orthotics/Lifts \_\_\_\_\_ Flat Feet

\_\_\_\_\_ Severe Health Problems \_\_\_\_\_ Hard Falls \_\_\_\_\_ Broken Bones

\_\_\_\_\_ Other Injuries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been under chiropractic care in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago was your last adjustment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Health History**

Have you... **Yes No** If yes, explain briefly:

…been hospitalized in the last 5 years? 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

…had any mental disorders? 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

…had any broken bones? 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

…had any strains or sprains? 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

…ever used orthotics? 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take minerals, herbs, or vitamins? 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is most of your day spent? 🞏 standing 🞏 sitting 🞏 other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old is your mattress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits**

None Light Moderate Heavy

Alcohol 🞏 🞏 🞏 🞏

Coffee 🞏 🞏 🞏 🞏

Tobacco 🞏 🞏 🞏 🞏

Drugs 🞏 🞏 🞏 🞏

Exercise 🞏 🞏 🞏 🞏

Sleep 🞏 🞏 🞏 🞏

Soft drinks 🞏 🞏 🞏 🞏

Salty foods 🞏 🞏 🞏 🞏

Water 🞏 🞏 🞏 🞏

Sugar 🞏 🞏 🞏 🞏

Dairy 🞏 🞏 🞏 🞏

**Family History**

If any blood relative has had any of the following conditions, please check and indicate which relative(s):

🞏 Alcoholism 🞏 Cancer 🞏 High blood pressure

🞏 Anemia 🞏 Diabetes 🞏 High cholesterol

🞏 Arteriosclerosis 🞏 Emphysema 🞏 Multiple sclerosis

🞏 Arthritis 🞏 Epilepsy 🞏 Osteoporosis

🞏 Asthma 🞏 Glaucoma 🞏 Stroke

🞏 Bleed easily 🞏 Heart Disease 🞏 Thyroid disease

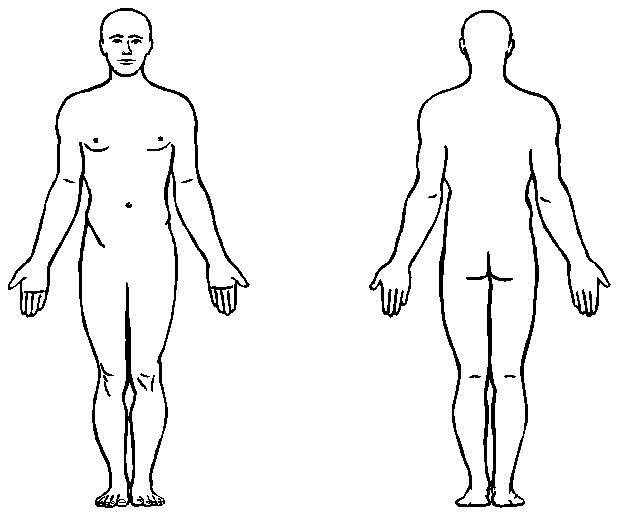
**Patient Intake Form**

Give a brief detailed description of the problem you are currently experiencing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it getting worse? 🞏 yes 🞏 no

Does it bother you (check appropriate box): 🞏 work 🞏 sleep 🞏 other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Mark areas of pain

**Patient Intake Form** (continued) Check box and indicate the age when you had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL** | **GASTROINTESTINAL** | **CARDIOVASCULAR** | **CHECK ANY CONDITIONS** |
| 🞏 Allergies | 🞏 Abdominal Pain | 🞏 High blood pressure | **YOU HAVE OR HAVE HAD:** |
| 🞏 Depression | 🞏 Bloody or tarry stool | 🞏 Low blood pressure | 🞏 Alcoholism |
| 🞏Dizziness | 🞏 Colitis Crohn’s | 🞏 Hardening of the arteries | 🞏 Anemia |
| 🞏 Fainting | 🞏 Constipation | 🞏 Irregular pulse | 🞏 Appendicitis |
| 🞏 Fatigue | 🞏 Diarrhea | 🞏 Pain over heart | 🞏 Arteriosclerosis |
| 🞏 Fever | 🞏 Difficult digestion | 🞏 Palpitation | 🞏 Asthma |
| 🞏 Headaches | 🞏 Diverticulosis | 🞏 Poor circulation | 🞏 Bronchitis |
| 🞏 Loss of sleep | 🞏 Bloated abdomen | 🞏 Rapid heartbeat | 🞏 Cancer |
| 🞏 Mental illness | 🞏 Excessive hunger | 🞏 Slow heart beat | 🞏 Chicken pox |
| 🞏 Nervousness | 🞏 Gallbladder trouble | 🞏 Swelling of ankles | 🞏 Cold sores |
| 🞏 Tremors | 🞏 Hernia |  | 🞏 Diabetes |
| 🞏 Weight loss | 🞏 Hemorrhoids | **RESPIRATORY** | 🞏 Eczema |
| 🞏 Weight gain | 🞏 Intestinal worms | 🞏 Chest pain | 🞏 Edema |
|  | 🞏 Jaundice | 🞏 Chronic cough | 🞏 Emphysema |
| **MUSCLE/JOINT** | 🞏 Liver trouble | 🞏 Difficulty breathing | 🞏 Epilepsy |
| 🞏 Arthritis/rheumatism | 🞏 Nausea | 🞏 Hay fever | 🞏 Goiter |
| 🞏 Bursitis | 🞏 Painful defecation | 🞏 Shortness of breath | 🞏 Gout |
| 🞏 Foot trouble | 🞏 Pain over stomach | 🞏 Spitting up blood | 🞏 Heartburn |
| 🞏 Muscle weakness | 🞏 Poor appetite | 🞏 Wheezing | 🞏 Heart disease |
| 🞏 Low back pain | 🞏 Vomiting |  | 🞏 Hepatitis |
| 🞏 Neck pain | 🞏 Vomiting of blood | **WOMEN ONLY** | 🞏 Herpes |
| 🞏 Mid back pain |  | 🞏 Congested breasts | 🞏 High cholesterol |
| 🞏 Joint pain | **GENITOURINARY** | 🞏 Hot flashes | 🞏 HIV/AID |
|  | 🞏 Bedwetting | 🞏 Lumps in breast | 🞏 Influenza |
| **SKIN** | 🞏 Bladder infection | 🞏 Menopause | 🞏 Malaria |
| 🞏 Boils | 🞏 Blood in urine | 🞏 Vaginal discharge | 🞏 Measles |
| 🞏 Bruise easily | 🞏 Kidney infection |  | 🞏 Miscarriage |
| 🞏 Dryness | 🞏 Kidney stones | Menstrual flow | 🞏 Multiple sclerosis |
| 🞏 Hives or allergies | 🞏 Prostate trouble | 🞏 Regular 🞏 Irregular | 🞏 Mumps |
| 🞏 Itching | 🞏 Pus in urine | 🞏 Pain/cramps | 🞏 Numbness/tingling |
| 🞏 Rash | 🞏 Stress incontinence | Days of flow \_\_\_\_\_\_\_\_ | 🞏 Pacemaker |
| 🞏 Varicose veins |  | 1st day last period \_\_\_\_\_\_\_\_ | 🞏 Osteoporosis |
|  | **URINATION** | Are you pregnant? \_\_\_\_\_\_\_ | 🞏 Pneumonia |
| **EYE, EAR, NOSE & THROAT** | 🞏 Overnight more than 2x | If yes, how many months? | 🞏 Polio |
| 🞏 Deafness | 🞏 More than 8x in 24 hours | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Rheumatic fever |
| 🞏 Ear ache | 🞏 Decreased flow/force | How many children do | 🞏 Stroke |
| 🞏 Eye pain | 🞏 Painful urination | you have? \_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Thyroid disease |
| 🞏 Gum trouble | 🞏 Urgency to urinate | Birth control method: | 🞏 Tuberculosis |
| 🞏 Hoarseness |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Ulcers |
| 🞏 Nasal obstruction |  | Date of last PAP test? |  |
| 🞏 Nosebleeds |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 🞏 Ringing of the ears |  | Date of last mammogram: |  |
| 🞏 Sinus infection |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 🞏 Sore throat |  | | |
| 🞏 Tonsillitis | **Please bring a list or list any medication(s) you are currently taking and why:** | | |
| 🞏 Vision problems | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**PATIENT HEALTH INFORMATION CONSENT FORM**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information (PHI) will be used, and I agree to these policies and procedures.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Patient Date**