NEW PATIENT INTAKE FORM

Date:_____

First Name MI Last Name DOB

Gender: Male Female Height:_____Weight:_____ Marital Status: Single Married Widowed Divorced

Address:_____

Street City State Zip Code

Phone Numbers		Preferred Method of Contact?	May we leave messages at this number?
Home	( )	□	YES NO
Work	( )	□	YES NO
Cell	( )	□	YES NO

Email address:_____

May we email you with appointment related information (paperwork updates, exercises, etc.)? YES NO

Appointment Reminders:

Germantown Chiropractic, PSC may employ a third party automated outreach and messaging system to use my personal information for the purpose of notifying me of upcoming appointments at the following numbers/email address as detailed above: Home Work Cell Email

Emergency Contact:

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Have you had any spinal x-rays of the area of complaint? Y N If yes, when and where?

_____

Have you had any MRI's or CT scans of the area of complaint? Y N If yes, when and where?

_____

Are your symptoms a result of: ☐Motor Vehicle Accident ☐Work related Accident ☐Neither/Other

Patient Name_____

What is your complaint? (Why are you seeing the doctor today?)_____

_____

When did your complaint start? Gradually Chronic/long term Other:_____

_____

How did your complaint start? Unknown Other:_____

_____

How often do you notice the pain? □Constant (76-100% of the time) □Frequent (51-75% of the time)
□Intermittent (26-50% of the time) □Occasional (0-25% of the time)

What makes it worse?_____

_____

What makes it better?_____

_____

Describe your complaint (Circle all that apply):

Achy	Stiff	Burning	Pinching	Shooting	Tingling
Dull	Sharp	Throbbing	Stabbing	Numb	Other:_____

What would you rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst imaginable pain?_____

Do you have any of the following? If so, where?
□ Numbness/Tingling_____
□ Spasms_____
□ Weakness_____

What activity/activities is/are difficult or that you cannot do now? Please list below and then circle a number describing your ability to perform this activity on a scale of 0-10, with 0 being completely unable to perform and 10 being able to perform without any limitation at all.

Activity	Functional Ability
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10

How are your symptoms changing? □getting better □not changing □getting worse

Patient Name_____

HEALTH HISTORY - Please read through the list and check the box next to each condition that applies to you.

Musculoskeletal - General

Now	Past	
□	□	Degenerative arthritis
□	□	Rheumatoid arthritis/ Gout
□	□	Compression fracture
□	□	Osteomyelitis
□	□	Osteoporosis

Musculoskeletal - Spine

Now	Past	
□	□	Poor Posture
□	□	Disc injury
□	□	Neck problem
□	□	Mid-back problem
□	□	Low back problem
□	□	Scoliosis
□	□	Ankylosing spondylitis
□	□	Difficulty swallowing because of neck pain
□	□	Pain/electric shocks in arm/leg on moving neck

Musculoskeletal - Extremity

Now	Past	
□	□	Hip or sacroiliac pain
□	□	Leg,Knee,ankle,foot pain
□	□	Shoulder pain
□	□	Arm,elbow,hand pain
□	□	Rib or chest pain

EENT

Now	Past	
□	□	Jaw or TMJ problem
□	□	Visual problems
□	□	Ear problems, infections or ringing
□	□	Chronic sinus problems
□	□	Face pain

Nervous System

Now	Past	
□	□	Headaches or migraines
□	□	Tingling or numbness of arms, legs, hands or feet
□	□	Pinched nerve or sciatica
□	□	Poor balance
□	□	Depression or Anxiety
□	□	Dizziness or vertigo
□	□	Seizures/Epilepsy
□	□	Recent progressive muscle weakness
□	□	Numbness of inner thighs/groin

GI/GU/Endocrine

Now	Past	
□	□	Abdominal pain
□	□	Constipation/Diarrhea
□	□	Heartburn/Acid Reflux/Ulcers
□	□	Uncontrolled Bladder/Bowel
□	□	Inflammatory bowel disease
□	□	Liver or gallbladder problems
□	□	Menstrual problems
□	□	Menopause symptoms

Cardio-Pulmonary

Now	Past	
□	□	Pacemaker/implanted device
□	□	Breathing trouble or Asthma
□	□	High blood pressure
□	□	History of stroke or aneurysm

Medication-Related Issues

Now	Past	
□	□	Medication dependence
□	□	Drug or Vaccination reaction
□	□	Current drug side-effects
□	□	3 or more months of steroid medications or intravenous drugs

Injuries and General

Now	Past	
□	□	Car crash/whiplash injuries
□	□	Work injuries
□	□	Ergonomic stress at work
□	□	Sports injuries
□	□	Drug or alcohol dependence or recovering
□	□	Psoriasis or psoriatic arthritis
□	□	Unexplained weight loss
□	□	Sleeping trouble
□	□	Get sick a lot/poor immune function
□	□	Fibromyalgia / Chronic fatigue
□	□	Tuberculosis, Hepatitis or HIV
□	□	Cancer or Tumor
□	□	Recent fever over 102°F
□	□	Blurred or double vision, dizziness, nausea or faintness
□	□	Constant pain that doesn't improve by changing positions or by lying down

GERMANTOWN CHIROPRACTIC

Past/Social/Family History

Surgeries: (Circle all that apply to you)

☐ Appendectomy	Cardiovascular	Cervical spine ☐	Hysterectomy
☐ Joint Replacement	Prostate	Lumbar spine ☐	Gall Bladder
Knee ☐	Shoulder	Thoracic spine	Hernia ☐
Hip ☐	Female/Male Surgery	Gastro-intestinal	Rectal
☐ Tonsillectomy	Sinus	Carpal Tunnel	Brain

Other _____

Family History: (Circle all that apply)

Osteoarthritis	Mother	Father	Sister	Brother
Rheumatoid Arthritis	Mother	Father	Sister	Brother
Cancer ☐	Mother	Father	Sister	Brother
Diabetes	Mother	Father	Sister	Brother
Heart Disease/Hypertension ☐	Mother	Father	Sister	Brother
Stroke ☐	Mother	Father	Sister	Brother

Medication List:

Medication Name	Dosage	Frequency	Reason

*You may bring a copy of your medication list to the office instead of filling out the above chart.

☐ I have given the office staff a copy of my medications to be scanned into my chart.

Medication Allergies: _____

Social History: (Check all that apply to you)

Caffeine use: ☐	occasional	often	never	
Drink Alcohol: ☐	occasional	often	never	
Chew Tobacco:	occasional	often	never	
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never	
Exercise:	daily	1 x/ week	2 x /week	3 x /week never
How long do you exercise?	>1 hour	<1 hour	> 30 minutes	< 30 minutes
How do you exercise?	Walking	Swimming	Running	Weight lifting
	Other _____			

Patient Name_____

Appointment Policy:

If you are more than 5 minutes late for an appointment, you may be asked to reschedule or wait until there is an opening in the schedule.

You will be charged a $25 missed appointment fee if you do not cancel within 24 hours of your appointment. You will only be charged this amount on your 3rd offense to allow for uncontrollable circumstances. If you have an insurance policy that does not allow missed appointment fees, you may be dismissed as a patient or only allowed to schedule same day appointments in the future.

I have read, understand, and accept the appointment policies as outlined above.

_____ _____

Patient Signature Date

HIPAA Privacy Practices

Would you like a copy of our Notice of Privacy Practices? YES NO

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Patient's Signature _____

List of People who may have access to your medical records:

1. _____
2. _____
3. _____
4. _____

I certify that I'm the patient or legal guardian listed above. I have read/understand all included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

_____ _____

Patient Signature Date