NEW PATIENT INTAKE FORM

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 #_____ ID

#_____ 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 Enhanced Health 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 Enhanced Health 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: _____

_____

_____

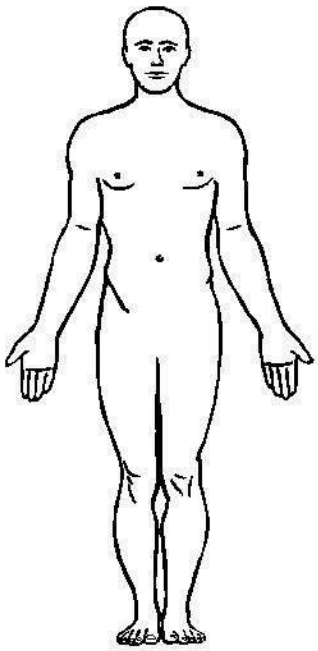
How long have you had this condition? _____ Is it getting worse? ☐ yes ☐ no

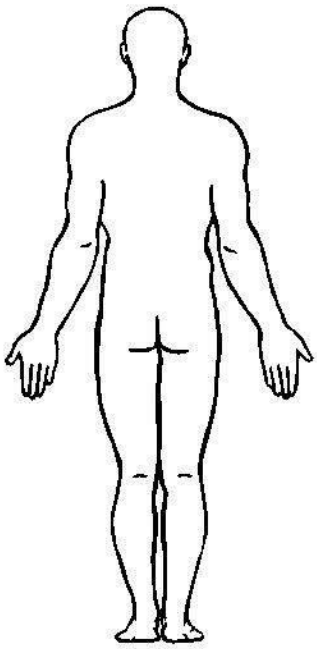
Does it bother you (check appropriate box): ☐ work ☐ sleep ☐ other: _____

What seemed to be the initial cause? _____

_____

Please mark your area(s) of pain on the figure(s) → → → **Patient Intake Form** (continued) Check box and indicate the age when you had any of the following:





GENERAL
- ☐ Allergies
- ☐ Depression
- ☐Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss
- ☐ Weight gain

MUSCLE/JOINT
- ☐ Arthritis/rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Bloody or tarry stool
- ☐ Colitis Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defecation
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

GENITOURINARY
- ☐ Bedwetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heart beat
- ☐ Swelling of ankles

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ Wheezing

WOMEN ONLY
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
- ☐ Regular ☐ Irregular

CHECK ANY CONDITIONS YOU HAVE OR HAVE HAD:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heartburn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AID
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps

☐ Itching
☐ Rash
☐ Varicose veins

EYE, EAR, NOSE & THROAT
☐ Deafness
☐ Ear ache
☐ Eye pain
☐ Gum trouble
☐ Hoarseness
☐ Nasal obstruction
☐ Nosebleeds
☐ Ringing of the ears
☐ Sinus infection
☐ Sore throat

☐ Tonsillitis
☐ Vision problems

☐ Pus in urine
☐ Stress incontinence

URINATION
☐ Overnight more than 2x
☐ More than 8x in 24 hours
☐ Decreased flow/force
☐ Painful urination
☐ Urgency to urinate

☐ Pain/cramps
Days of flow _____
1st day last period _____
Are you pregnant? _____
If yes, how many months?
_____
How many children do
you have? _____
Birth control method:
_____
Date of last PAP test?
_____
Date of last mammogram:
_____

☐ Numbness/tingling
☐ Pacemaker
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers

Please list any medication(s) you are currently taking and why:
_____
_____

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**