

## New Patient Health Intake Form

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

If married, Spouse's Name: \_\_\_\_\_ # of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

I give you permission to share a brief summary of my case and diagnosis with my primary care physician.

Yes  No Initial: \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when? \_\_\_\_\_

Name of most recent Chiropractor: \_\_\_\_\_

Referred by: \_\_\_\_\_

### 1. Reasons for seeking chiropractic care:

Primary reason:

\_\_\_\_\_

Secondary reason:

\_\_\_\_\_

### 2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

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

### 3. Past Health History:

#### A. Please indicate if you have a history of any of the following:

- Anticoagulant use  Heart problems/high blood pressure/chest pain  Bleeding problems  
 Lung problems/shortness of breath  Cancer  Diabetes  Psychiatric disorders  
 Bipolar disorder  Major depression  Schizophrenia  Stroke/TIA's  Other \_\_\_\_\_  
 None of the above

#### B. Previous Injury or Trauma:

\_\_\_\_\_

Have you ever broken any bones? Which?

\_\_\_\_\_

C. Allergies: \_\_\_\_\_

Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

## New Patient Health Intake Form

### D. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

### E. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

### F. Prior Imaging (ie., X-rays, MRI, CT, etc):

What Images were performed?	Reason they were done:
_____	_____
_____	_____
_____	_____

### 4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Strokes/TIA's         | <input type="checkbox"/> Headaches                    |
| <input type="checkbox"/> Cardiac disease     | <input type="checkbox"/> Neurological diseases | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Psychiatric disease | <input type="checkbox"/> Adopted/Unknown       | <input type="checkbox"/> Cardiac disease below age 40 |
| <input type="checkbox"/> Other _____         |  | <input type="checkbox"/> None of the above            |

Deaths in immediate family: \_\_\_\_\_

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

### Social and Occupational History:

#### A. Job description:

\_\_\_\_\_

#### B. Work schedule:

\_\_\_\_\_

#### C. Recreational activities:

\_\_\_\_\_

#### D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

\_\_\_\_\_

## New Patient Health Intake Form

### Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing    COPD    Emphysema    Other \_\_\_\_\_    None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries    Congestive heart failure    Murmurs or valvular disease    Heart attacks/MIs    Heart disease/problems    Hypertension    Pacemaker    Angina/chest pain    Irregular heartbeat    Other \_\_\_\_\_  
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision    One-sided weakness of face or body    History of seizures    One-sided decreased feeling in the face or body    Headaches    Memory loss    Tremors    Vertigo    Loss of sense of smell  
 Strokes/TIAs    Other \_\_\_\_\_    None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease    Hormone replacement therapy    Injectable steroid replacements    Diabetes  
 Other \_\_\_\_\_    None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones    Hematuria (blood in the urine)    Incontinence (can't control)    Bladder Infections  
 Difficulty urinating    Kidney disease    Dialysis    Other \_\_\_\_\_    None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea    Difficulty swallowing    Ulcerative disease    Frequent abdominal pain    Hiatal hernia    Constipation  
 Pancreatic disease    Irritable bowel/colitis    Hepatitis or liver disease    Bloody or black tarry stools  
 Vomiting blood    Bowel incontinence    Gastroesophageal reflux/heartburn    Other \_\_\_\_\_    None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia    Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)    HIV positive  
 Abnormal bleeding/bruising    Sickle-cell anemia    Enlarged lymph nodes    Hemophilia  
 Hypercoagulation or deep venous thrombosis/history of blood clots    Anticoagulant therapy    Regular aspirin use  
 Other \_\_\_\_\_    None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns    Significant rashes    Skin grafts    Psoriatic disorders    Other \_\_\_\_\_    None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis    Gout    Osteoarthritis    Broken bones    Spinal fracture    Spinal surgery    Joint surgery  
 Arthritis (unknown type)    Scoliosis    Metal implants    Other \_\_\_\_\_    None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis    Depression    Suicidal ideations    Bipolar disorder    Homicidal ideations    Schizophrenia  
 Psychiatric hospitalizations    Other \_\_\_\_\_    None of the above

Is there anything else in your past medical history that you feel is important to your care here?

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Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

## New Patient Health Intake Form

*Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.*

Symptom 1 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What movements/activities make the symptom worse?
  - Please describe: \_\_\_\_\_
- What makes the symptom better?
  - Please describe: \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor's Notes:

Symptom 2 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What movements/activities make the symptom worse?
  - Please describe: \_\_\_\_\_
- What makes the symptom better?
  - Please describe: \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor's Notes:

## New Patient Health Intake Form

Symptom 3 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What movements/activities make the symptom worse?
  - Please describe: \_\_\_\_\_
- What makes the symptom better?
  - Please describe: \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor's Notes:

Symptom 4 \_\_\_\_\_

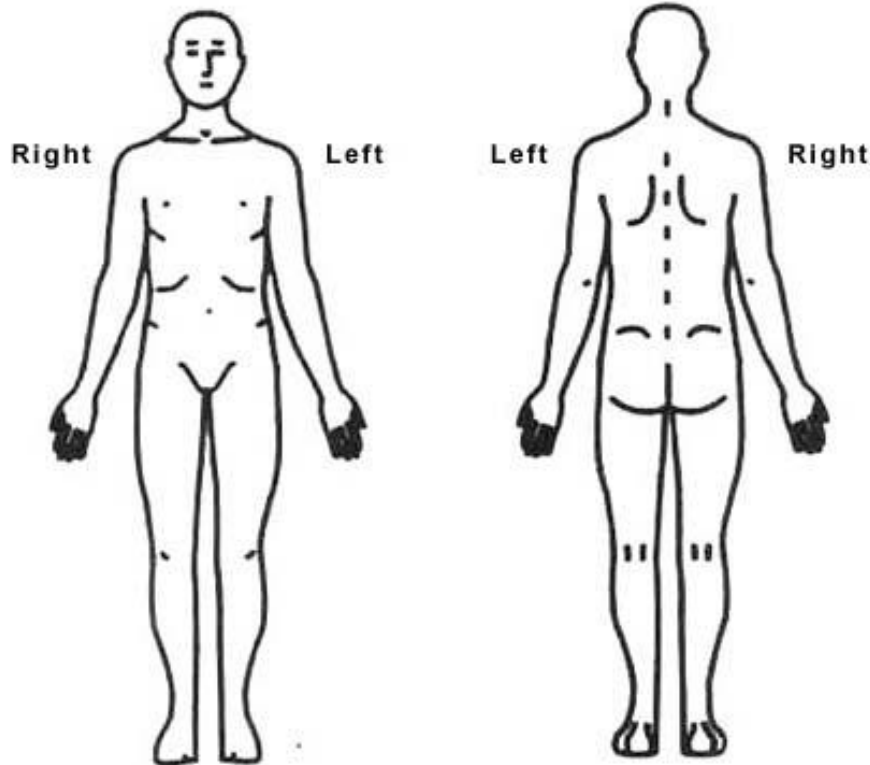
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What movements/activities make the symptom worse?
  - Please describe: \_\_\_\_\_
- What makes the symptom better?
  - Please describe: \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor's Notes:

Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

## New Patient Health Intake Form

Please indicate sites of **pain** with an "X". (×××)  
Does the **pain radiate (travel)**? If so, mark with an "arrow". (→→→)

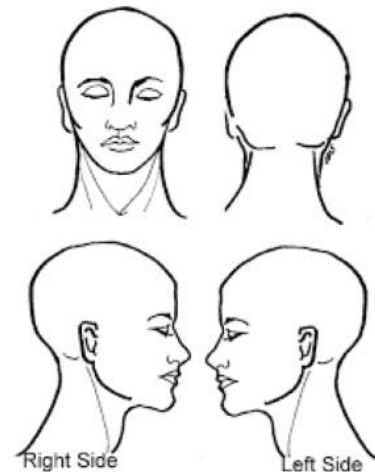


### Do you have headaches?

Yes     No, skip to next page.

If yes, please answer the following:

- Mark where you get your headache(s) with an "X"
- On a scale from 0-10, with 10 being the worst, indicate the intensity of your headache: 1 2 3 4 5 6 7 8 9 10
- What describes your headaches? (circle all that apply)  
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other: \_\_\_\_\_
- How often do they occur?  
\_\_\_\_\_ X/week    \_\_\_\_\_ X/month    \_\_\_\_\_ Sporadic
- Are your headaches worse at certain times of the day or night?  
Morning    Afternoon    Evening    Night    Unaffected time of day
- When did your headaches begin? \_\_\_\_\_
- What makes your headaches worse? \_\_\_\_\_
- What makes your headaches better? \_\_\_\_\_



Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

## New Patient Health Intake Form

### HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

## New Patient Health Intake Form

### PRIMARY INSURANCE:

INSURANCE COMPANY: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP TO INSURED: \_\_\_\_\_

INSURED'S BIRTHDATE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

### SECONDARY INSURANCE

INSURANCE COMPANY: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP TO INSURED: \_\_\_\_\_

INSURED'S BIRTHDATE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

### RELEASE OF INFORMATION:

I \_\_\_\_\_ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: (LAST, FIRST, MI): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: (LAST, FIRST, MI): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Swickard Chiropractic Clinic of Shawnee, P.A. for services performed.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_



## New Patient Health Intake Form

### Electronic Health Records Intake Form

*This form complies with CMS EHR incentive program requirements*

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Email address:** \_\_\_\_\_@\_\_\_\_\_

**Preferred method of communication for patient reminders (Circle one):** Email / Phone / Mail

By providing my e-mail address, I understand that authorized personnel from Swickard Chiropractic may communicate with me regarding scheduling, treatment, receipts, statements, appointment reminders, health education, and promotional information. If you do not consent to e-mail communication, please initial here. \_\_\_\_\_

**DOB:** \_\_/\_\_/\_\_\_\_ **Gender (Circle one):** Male / Female **Preferred Language:** \_\_\_\_\_

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Smoking Start Date (Optional):** \_\_\_\_\_

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications? (Include regularly used over the counter medications)**

Medication	Dosage and Frequency (i.e. 5mg once a day, etc.)	Reason for Taking

**Do you have any medication allergies?**

Medication	Reaction	Onset Date	Additional Comments

**I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

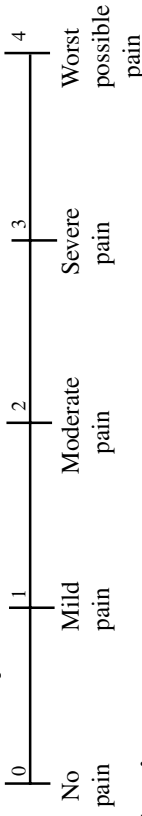
Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

# Functional Rating Index

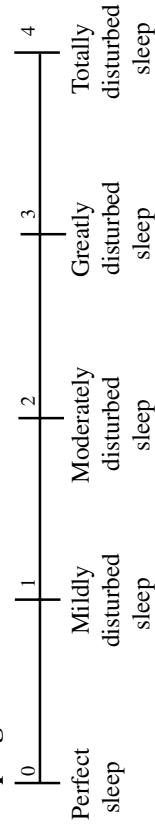
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

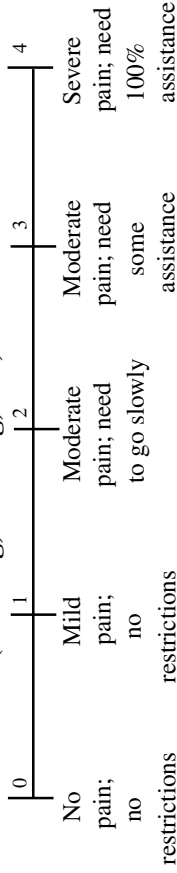
## 1. Pain Intensity



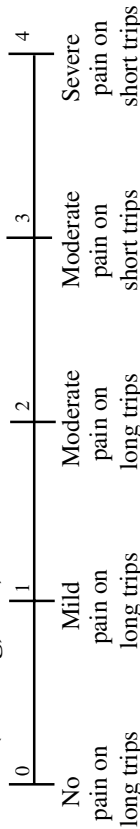
## 2. Sleeping



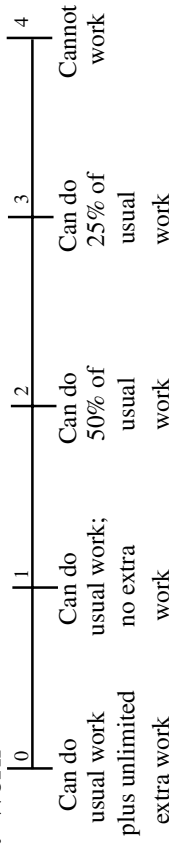
## 3. Personal Care (washing, dressing, etc.)



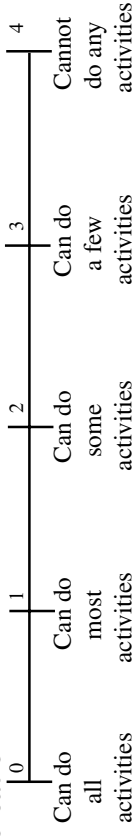
## 4. Travel (driving, etc.)



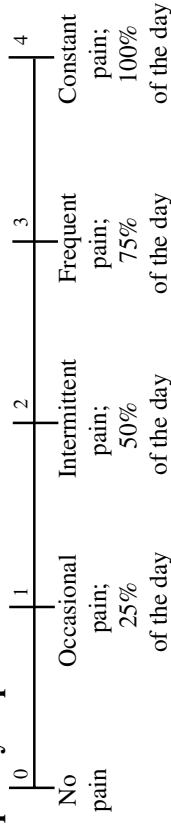
## 5. Work



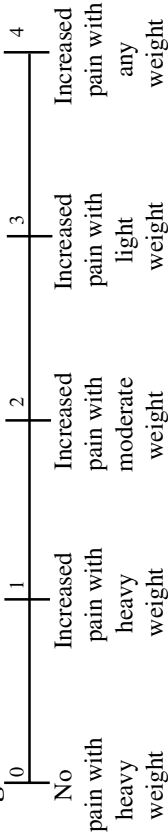
## 6. Recreation



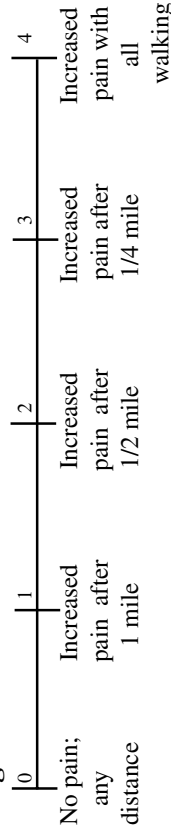
## 7. Frequency of pain



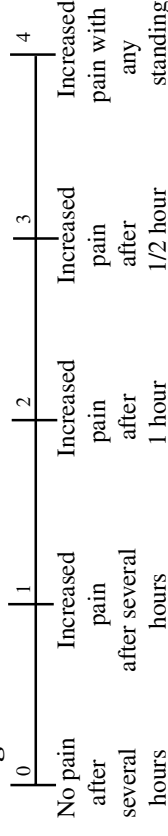
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

**PRINTED**

**Total Score** \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_