

Collins CHIROPRACTIC CENTER - NEW PATIENT INTAKE FORM

NAME: _____ Today's DATE: ____/____/____

Address: _____ City: _____ STATE: ____ Zip: _____

PHONE HOME: _____ Work: _____ Cell: _____

EMAIL: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: ____/____/____ AGE: _____ MARITAL STATUS: MARRIED SINGLE WIDOW

Employer/Address: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

INSURANCE:

NAME OF YOUR INSURANCE COMPANY: _____

NAME OF THE INSURED: _____ DATE OF BIRTH: ____/____/____

CHIROPRACTIC:

HAVE YOU PREVIOUSLY BEEN UNDER CHIROPRACTIC CARE? YES NO

IF YOU ANSWERED "YES", WHEN WAS YOUR LAST VISIT TO THEIR OFFICE? _____

WHAT WERE YOU TREATED FOR? _____

PATIENT COMPLAINT:

WHAT COMPLAINT(S) BROUGHT YOU TO OUR OFFICE? _____

WHEN did THE COMPLAINT(S) FIRST BEGIN? _____

IF YOU KNOW, WHAT WAS THE CAUSE OF YOUR COMPLAINT(S)? _____

WHO ELSE HAS TREATED YOU FOR THIS COMPLAINT(S)? _____

ARE YOU BEING MEDICATED FOR THIS COMPLAINT(S)? YES NO

CHARACTER: SHARP DULL BURNING NUMB TINGLING GRIPPING SHOOTING

FREQUENCY: CONSTANT > 75% FREQUENT > 50% OCCASIONAL > 25% INTERMITTENT < 25%

WHAT TIME OF DAY IS YOUR COMPLAINT(S) WORSE? _____

WHAT MAKES YOUR COMPLAINT(S) WORSE? _____

WHAT MAKES YOUR COMPLAINT(S) BETTER? _____

IS YOUR CONDITION: BETTER WORSE UNCHANGED

HAVE YOU LOST ANY WORK DUE TO THIS CONDITION? YES NO IF "YES", HOW MUCH? _____

WHAT HOME CARE ARE YOU PRESENTLY USING? HEAT ICE REST MEDICATION NONE

IS YOUR COMPLAINT THE RESULT OF AN AUTOMOBILE ACCIDENT? YES NO

IF YOU ANSWERED "YES", WHEN WAS THE MOST RECENT ACCIDENT? _____

IS YOUR COMPLAINT THE RESULT OF A WORK RELATED INJURY? YES NO

IF YOU ANSWERED "YES", WHEN WAS THE MOST RECENT INJURY? _____

IF FEMALE, ARE YOU PREGNANT OR A POSSIBILITY OF BEING PREGNANT? YES NO

WHAT WAS THE DATE OF YOUR LAST MENSTRUAL PERIOD? ____/____/____

WHAT MEDICATIONS ARE YOU PRESENTLY ON AND WHAT CONDITION(S) ARE THEY FOR?

ATTESTATION, REQUEST AND CONSENT FOR TREATMENT:

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND PROVIDED BY MYSELF FOR THE BENEFIT OF DR. JEFFREY W. COLLINS OF THE COLLINS CHIROPRACTIC CENTER SO THAT HE MAY BETTER UNDERSTAND MY CONDITION. I REQUEST AND GIVE MY CONSENT TO BE TREATED BY DR. JEFFREY W. COLLINS.

PATIENT'S SIGNATURE

Today's DATE