Workman Chiropractic New Patient Intake Form

Patient Data **Date**

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Spouse Data

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

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

Doctor's Signature _____

Patient Name **Date**

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never

Other _____

Family History: (Check all that apply)

Arthritis: Parent Sibling
Cancer: Parent Sibling
Diabetes: Parent Sibling
Heart Disease Parent Sibling
Hypertension Parent Sibling
Stroke Parent Sibling
Thyroid Parent Sibling
Other _____

Occupational Activities: (Check one that best describes your job description)

Administration Business Owner Clerical/Secretary Computer User
Heavy Equipment operator Daycare/Childcare Construction Health Care
Food Service Industry Medium Manual Labor Manufacturing Home Services
Heavy Manual Labor Light Manual Labor Executive/Legal Housekeeper
Other _____

Doctor's Signature _____

Patient Name_____Date_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No

Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

_____

_____

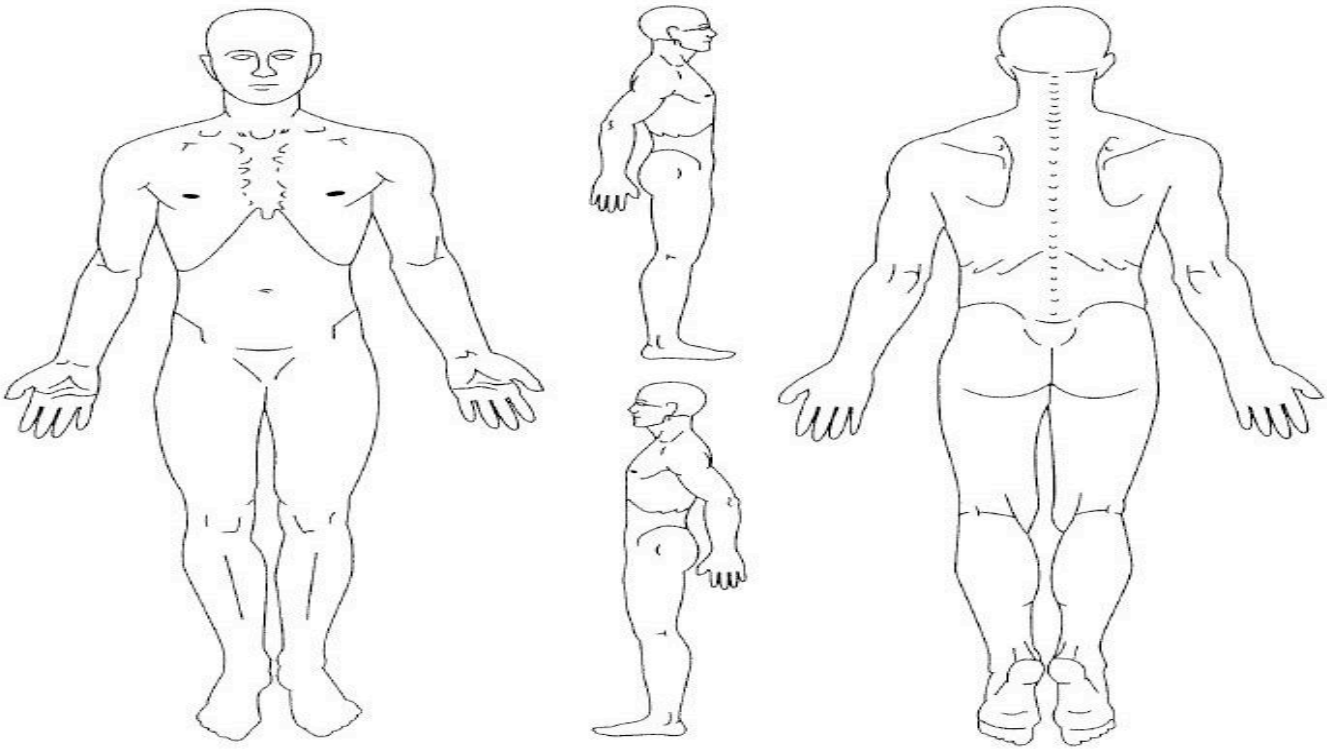
Doctor's Signature _____

Patient Name_____Date_____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? **Month**_____ **Day**_____**Year** _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Doctor's Signature _____

Patient Name _____ **Date** _____

How are your symptoms changing? Getting better Not changing Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ **Score** _____

Description of Work: _____

Condition's Effect On Job Performance: ù **No Effect** ù **Mild** (painful can do) ÿ **Mod** (painful limited ability)
ù **Mod/Sev** (limited duty) ù **Sev** (no limited duty) ÿ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Care –Infirm Family:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Carrying Groceries:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Change Posn–Sit-Stand:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Climb Stairs:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Driving:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Extended Computer Use:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Feeding:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Household Chores:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Kneeling:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Lift Children:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Lifting:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Pet Care:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Reading (Concentration):	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Self Care–Bathing:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Self Care–Dressing:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Self Care–Shaving:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Sexual Activities:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Sleep:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Static Sitting:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Static Standing:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Walking:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform
Yard Work:	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (Limited)	ÿ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (limited)	ÿ **Sev** Unable to Perform
_____	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (limited)	ÿ **Sev** Unable to Perform
_____	ÿ **No Effect**	ÿ **Mild** Painful (Can do)	ÿ **Mod** Painful (limited)	ÿ **Sev** Unable to Perform

Doctor's Signature _____

Patient Name_____Date_____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

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.

Print Patient's Name _____

Patient's Signature _____Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____

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