Touch Chiropractic Patient Intake Form

PERSONAL INFORMATION:

Patient Name_____ Birthdate_____ Gender_____

Address_____City_____ State_____ Zip_____

Primary Contact #(___)_____cell/home/work Secondary #(___)_____cell/home/work

Email_____ Referred By_____

Emergency Contact Name_____ Primary Contact #(___)_____cell/home/work

Address_____City_____ State_____ Zip_____

Secondary Contact #(___)_____cell/home/work Relationship_____

EMPLOYMENT INFORMATION:

Occupation_____Employer_____ Work Phone(___)_____

Address_____City_____ State_____ Zip_____

INSURANCE INFORMATION:

Primary Plan Subscriber Name_____ Subscriber's DOB_____

Health Plan_____ Subscriber ID#_____ Group/Policy#_____

Secondary Plan Subscriber Name_____ Subscriber's DOB_____

Health Plan_____ Subscriber ID#_____ Group/Policy#_____

Do you have Medicare? ☐Yes ☐No

Primary Care Physician Name_____ PCP Phone Number (___)_____

Describe your current problem and how it began: ☐Headache ☐Neck Pain ☐Mid-back Pain ☐Low Back Pain ☐Other_____

Is the problem: ☐Work Related ☐Auto Accident Related ☐N/A

Date Problem Began:_____ How Problem Began:_____

_____

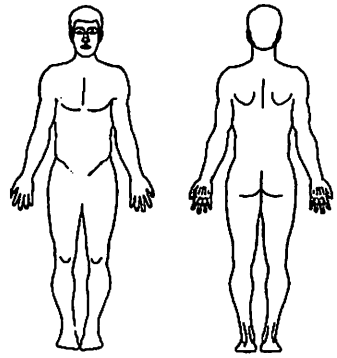
_____

Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Please describe your pain: Sharp Dull Throbbing Numb Burning Tingling Radiating to:_____

How often are your symptoms present?

☐0-25% ☐26-50% ☐51-75% ☐76-100%

Intermittent Constant

In the past week, what daily activities (e.g. work, social activities, or household chores) has your current condition affected?

_____

_____

Touch Chiropractic Patient Intake Form

Have you had any X-Rays, MRI, and/or CT Scan for your area(s) of complaint? ☐Yes ☐No

Date(s) Taken:_____ What areas were imaged?_____

Have you seen any other doctors for your current episode/condition? ☐Yes ☐No

Doctor's Name:_____ Phone Number (___)_____

Address_____ City_____ State_____ Zip Code_____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke *Date:*_____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Cancer/Tumor *Explain:*_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems *Explain:*_____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Current Pregnancy - *# of weeks*_____
☐ Abnormal Weight ☐Gain ☐Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries *List:*_____
_____
☐ Medications *List:*_____
_____

Family History: ☐Cancer ☐Diabetes ☐High Blood Pressure ☐Heart Problems/Stroke ☐Rheumatoid Arthritis

Additional Information for the Doctor:_____
_____
_____

I certify to the best of my knowledge, the above information is complete and accurate. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Touch Chiropractic will prepare any necessary forms and, as a courtesy, will bill my insurance company on my behalf. Any amount authorized to be paid directly to Touch Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also agree that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Lastly, I agree to inform Touch Chiropractic of any current or anticipated changes in my insurance coverage.

Patient Signatue_____ Date_____

Guardian Signature Authorizing Care_____ Date_____