NEW PATIENT INTAKE

HIGH POINT CHIROPRACTIC

Name: _____ Date: _____

Birth Date: _____ Age_____

Address: _____City:_____ State:_____ Zip:_____

Home Phone (____)_____Cell (____)_____

Email Address: _____

Occupation: _____ Employer: _____

Single____ Married____ Spouse's Name _____ Children_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

What is your chief complaint?_____

Have you seen a Chiropractor before? _____ If yes, when?_____

Check all symptoms you have ever had even if they do not seem related to your current problem.

___Headaches	___Pins and Needles in legs	___High/Low Blood Pressure	___Dizziness
___Arthritis	___Back Pain	___ Pins & needles in arms/legs	___Fatigue
___Ringing in ears	___Digestive Problems	___Numbness in fingers/toes	___Cold Feet/Hands
___Depression	___Cancer	___Menstrual irregularity	___Thyroid Problem
___Sleeping problems	___Neck Stiffness/Pain	___Heartburn	___Loss of Balance
___Heart Attack/Stroke	___Urinary Problems	___TMJD	___Shoulder Pain

Has your condition been getting better, worse, or staying the same?_____

What activities make your condition worse? _____

What activities make your condition better?_____

Have you seen a doctor for this condition?_____ Dr. Name: _____

Injuries or illnesses that you have had that are not listed above:_____

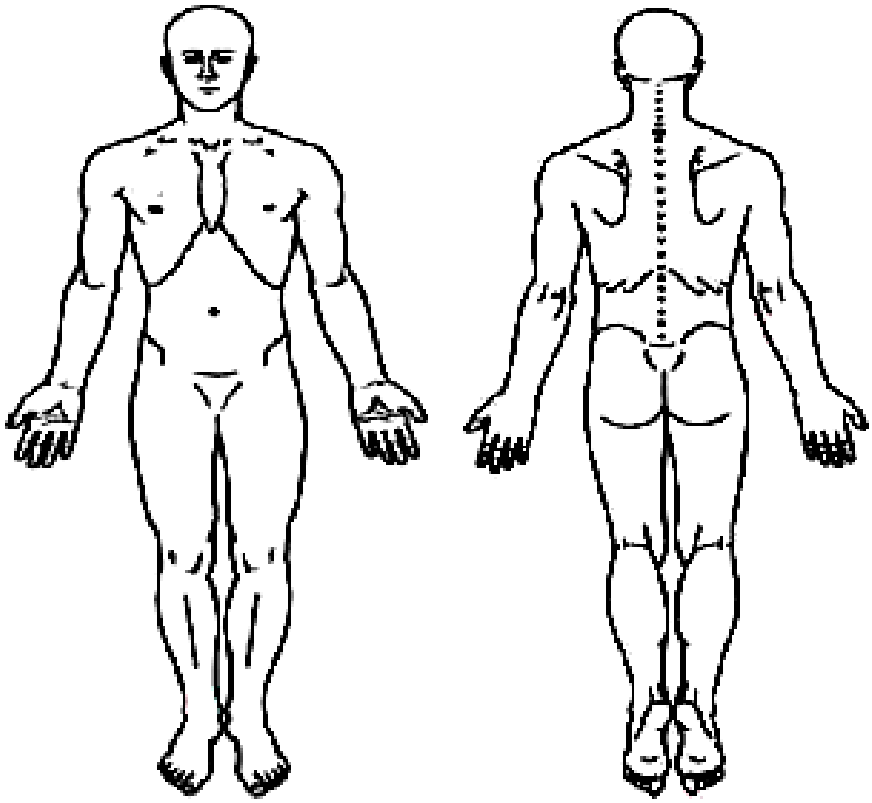
Any surgeries or hospitalizations?_____

Please list any medications you are taking: _____

_____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, *dull, sharp, constant, off and on, when standing, when sitting, etc., etc.*

COMPLETE THESE DIAGRAMS



I hereby authorize the Doctors to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

1. **I understand that most care is given in an open setting. A private room is available upon request.**

2. I consent to receive communication from HPC (appointment reminders) via email, text and telephone at the numbers/addresses listen on this intake form. If I should withdraw my consent, I will notify the office in writing.

3. This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient's Signature_____**Date**_____

Guardian's Signature_____**Date**_____