NEW PATIENT INTAKE

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? _____

___Instagram ___Facebook ___Google Search ___Website

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 ___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

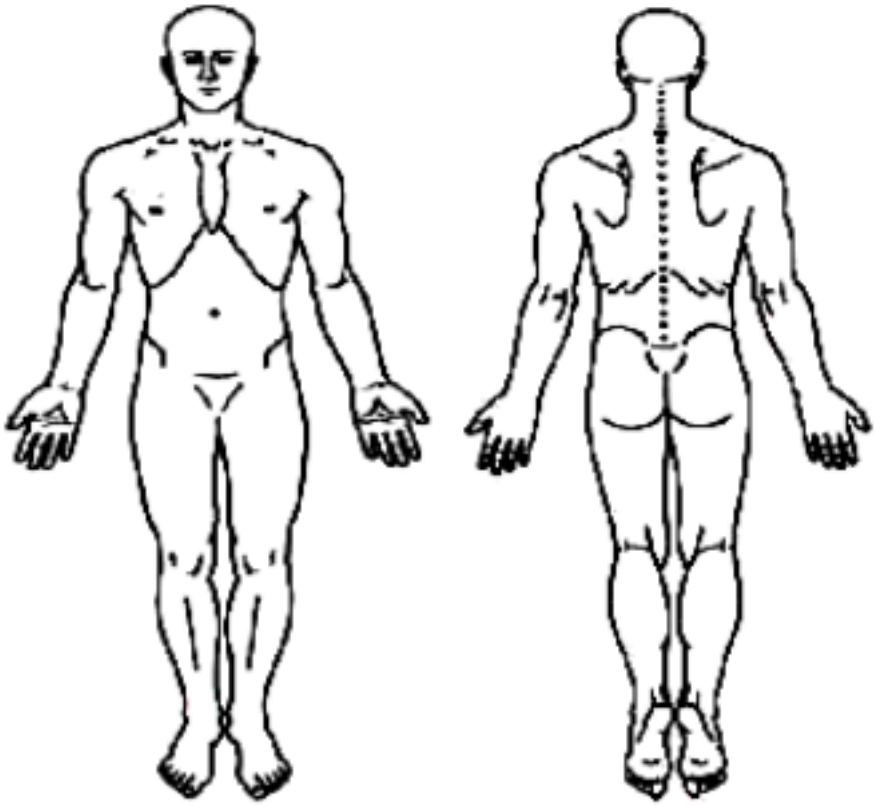
___Heart Attack/Stroke ___Urinary Problems ___TMJD ___Shoulder Pain

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 listed 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**_____