New Patient Intake Form

Patient Name: ____ **Date:** _________________
Address: ______________________________ **City:** ______________ **State:** ______ **Zip:** ________
Home Phone: ________________ **Cell Phone:** _________________ **Work Phone:** ____________
E-mail address: ____
Gender: ________________ **Birthdate:** _________________ **Marital Status: M S W D**
Employer Name: ________________________ **Occupation:** ____________________________
Guardian (for minors): Name: _________________ **Relation:** ____________ **Phone:** ____________
Emergency Contact: Name: _________________ **Relation:** ____________ **Phone:** ____________
How were you referred to our office? ____
Family Physician: __________________________________ **Clinic Phone (____)** ______________

May we share your case with your above listed physician for integrated and coordinated care? ☐Yes ☐No

Coach / Trainer _________________ **School** **Affiliation**
_______________ **Primary Sport** __________

May we share your case with your above listed coach or trainer for integrated and coordinated care? ☐Yes ☐No

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 ______ / _____ / ______

Cleargage Financial Payment Plan System: ****PLEASE READ so that we can be better prepared****

Cleargage is a HIPPA compliant payment plan system. So that way you can get the treatment you need without having to worry about the financial burden. Please fill out your SS# and Driver's License and the system will do a soft credit check (will **not** affect your score) so we can deliver a payment options best suited for you.

SSN: __________ - ________-_____________ **Driver's License #/State:** ______________

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________________

[Type here]
Doctor's Signature _________________________________

History of Present Illness:

What is your major symptom? ____

Date symptoms appeared, or accident happened: ____

Is this due to: □Auto □Work □Workouts □Other ____

Physical Demand of work? Sedentary, active, etc.______________________ **Days lost from work**: ____________

What does this prevent you from doing or enjoying? *(kids, working out, etc.)* ________________________________

Is this a recurrence? □Yes □ No

If yes, when was the first time you noticed this problem and how did it originally occur?

____

Has it become worse recently? □Yes □ No □ Same □ Better □ Gradually Worse

If yes, when and how? ____

How frequent is the condition? □ Constant throughout the day □ Comes and goes during the day □ Only present with movement or activity

How long does it last? □ All Day □ Few Hours □ Minutes

Describe the pain: □ Dull □ Achy □ Sharp □ Shooting □ Numbness □ Tingling □ Burning □ Radiating □ Other ____

Is there anything you can do to relieve the problem? *(stretching, medication, etc.)* □Yes □ No

If yes, describe. If no, what have you tried that has not helped?

____

____

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □ Gym □ Other ____

Please list your pre-existing injuries and past surgeries. No matter how small. (example, broken bones, sprained ankle in high school, car accidents, surgeries, C-section, etc.) **And the Dates** Why do I need them? *It is due to your bodies compensations resulting from your past*

____

____

____

____

Have you been to any other healthcare provider for your issues? (*Circle the provider and tell why)*

Chiropractor Physical Therapist Massage Therapist Acupuncturist MD Surgeon Other ________________

Why? And did is help? ____

Are there any other conditions or symptoms that may be related to your major symptom? □Yes □ No

If yes, describe: ____

Are there other unrelated health problems? □Yes □ No If yes, describe: ___________________________________

____

____

[Type here]

Doctor's Signature ____

Other factors that could be affecting your symptoms (Please be detailed with this part)

When your symptoms first started was there a stress that occurred in your life? (*death, job, kids, sickness, etc*.)
____

How is your **stress level**? 0 – 10 ______ Why? ____

How is your **energy** level? 0 – 10 ______ Constantly tired? Yes No Tired after lunch? Yes No

Do you drink **coffee**? Yes No How much? __________ **Energy drinks**? Yes No How many a week? _________

How long do you sleep? _____ hrs. Sleep **Apnea**? Yes No Do you use a machine? Yes No For how long? _____

Trouble **falling asleep**? Yes No Fall asleep fine but wake up and then **can not go back to sleep**? Yes No

Lots of Sleep but **still Tired**? Yes No **Hot Flashes**? Yes No

Going to use the bathroom **more than 1 time a night**? Yes No How many times? ________

Men- prostate issues? Yes No Women – menopause? Yes No Fibroids? Yes No

Digestion

Bloating? Yes No What foods? ________ Constipation? Yes No What foods?_______

Irritable Bowel? Yes No What foods? ________ Heart Burn? Yes No What foods? _______

Cravings (circle them)

Sweets / Starches / Salt / Chocolate / Not satisfied

Inflammation

Arthritis conditions? Yes No ______ Asthma? Yes No How long? _____ Sinus issues? Yes No How long? _____

Auto-immune issues? Yes No more info ____

For Women – Menstrual Cycle (please circle)

Heavy cramping / Irregular cycle / Infertility / Fibroids / Polycystic ovarian syndrome (PCOS)

For how long?___________________ Has anything helped? ________________________________

Medications (for what symptoms, for how long, is it helping)

____
____

Weight Issues

Are you trying to lose or gain weight? Yes No If so, how is that process going? Good Bad Stalled out

Tell me how long? What you have tried? What has worked? Not worked? Etc…… (for dieting goes)

____
____
____
____
____
____

[Type here]

Doctor's Signature ______________________________________

OMEGA CHIROPRACTIC
Sports Performance & Nutrition

____

Take Supplements? Yes No if yes, what ____

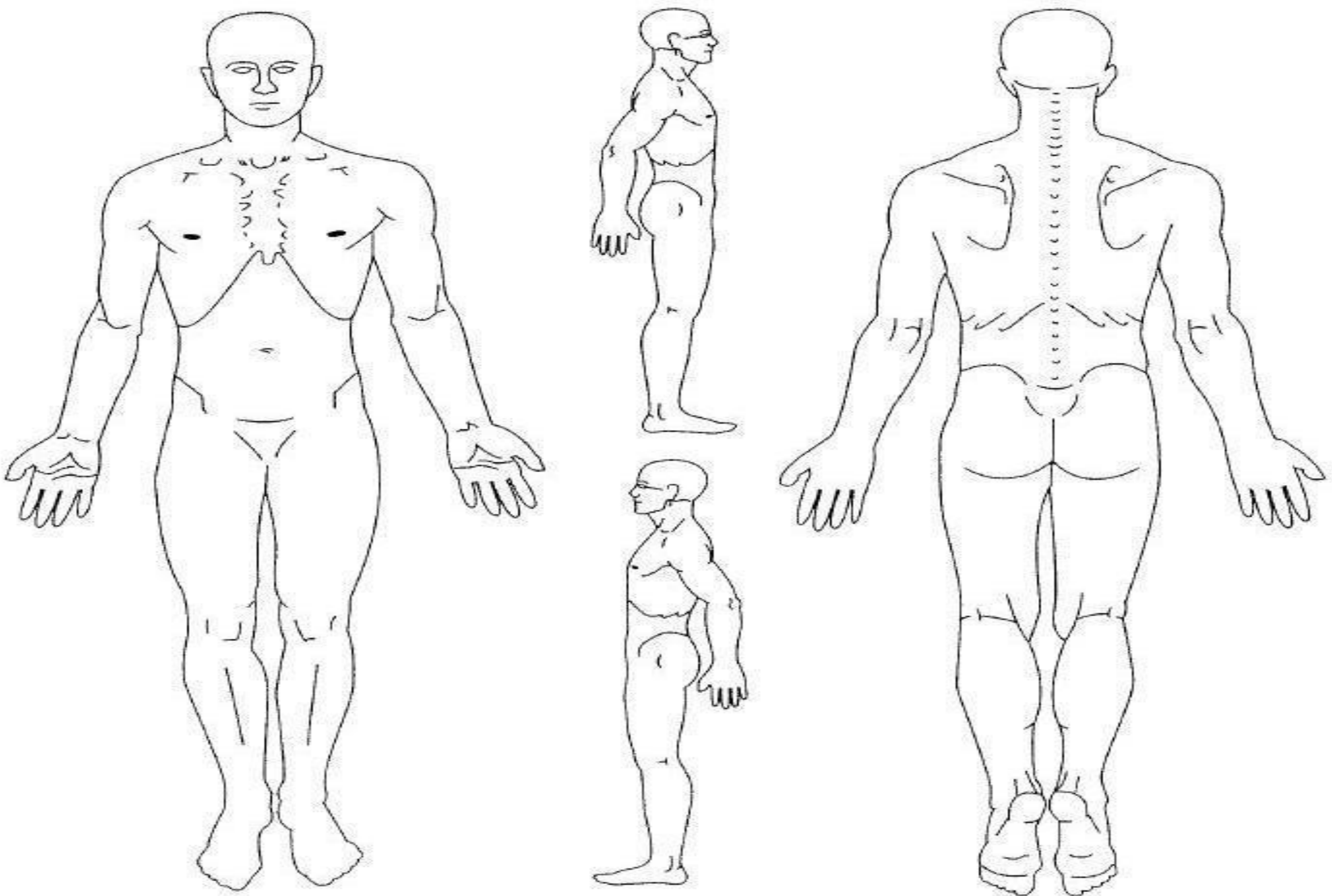
Patient Name____**Date**_______________________

Are you pregnant? Yes_____ No ______N/A______

Please list your symptoms in order of severity beside the picture below, with worse symptom being #1

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



On the line below, please indicate your current level of pain/discomfort for each area of complaint

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

No Pain **Emergency Room**

****Please add any additional info that would be important for understanding your issues. This could be how it happened in detail, does the pain travel (show on picture above) Broken bones, surgeries, arthritis, cancer, strokes, circulatory issues, congenital disease, family history, etc.****_______________________________________

____

____

[Type here]

Doctor's Signature ____

[Type here]

Doctor's Signature ______________________________________