New Patient Form

1. First Name: Last Name: DOB:

Social Security Number:

2. MRN #:

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

ABOUT YOU

3. Home Address

Address 1 Address 2

City State Zip Code

4. Contact Information

Mobile Phone Home Phone

Primary Email Address

5. Demographic Information

Sex at birth:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

6. Spouse's Name:

7. Number of Children:

8. Personal Information

Height - Feet:

Height - Inches:

Weight (in pounds):

9. Do you have insurance?

○ Yes ○ No

10. Insurance Payer

Insurance Payer

11. Insurance Policy Information:

Insurance Plan Name

ID/Policy Number:

Group Number:

Relationship to Patient:

○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name:

Insured's Date of Birth:

12. Insurance Card Upload

13. Emergency Contact Information

Emergency Contact Name:

Contact Phone Number:

Relationship to Patient:

14. Employer Information

Employment Status:

○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name:

Occupation:

Physical Work Duties:

15. Referral Information

Referring Physician:

Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

VISIT PURPOSE

16. Select the main reason for this visit:

- ○ Auto Accident (job related)
- ○ Auto Accident (personal)
- ○ New Complaint
- ○ Previous patient, new complaint

AUTO ACCIDENT

17. When did the accident occur?

Where in the vehicle were you at the time of the accident?

In what direction were you looking at the time of impact?

18.

	Yes	No/Unsure
Were you wearing a seatbelt?		
Did the airbag deploy?		
Did you come in contact with anything at the time of the collision?		
Did you receive an injury to the head?		
Did you lose consciousness?		
Did your head hit the headrest?		

19. Which part of your vehicle was impacted? Choose all that apply.

	Yes	No
Front right		
Front left		
Front head on		
Rear end- center		
Rear right		
Rear left		
Right side (passenger's side)		
Left side (driver's side)		
Unknown		

How much damage did your vehicle endure?

20. In what direction was your vehicle moving?

What was the approximate speed of your vehicle?

What was the extent of the damage to your vehicle?

In what direction was the other vehicle moving?

What was the approximate speed of the other vehicle?

What was the extent of the damage to the other vehicle?

21.

	Yes	No
Was your vehicle towed from the scene?		
Did police arrive at the scene?		
Was an accident report taken?		
Did Emergency Medical Services arrive at the scene?		

22. How did you leave the scene of the accident?

23. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen		
Back		
Chest		
Face		
Head		
Neck		
Right shoulder, elbow, arm or hand		
Left shoulder, elbow, arm or hand		
Right hip, thigh, knee, leg or foot		
Left hip, thigh, knee, leg or foot		

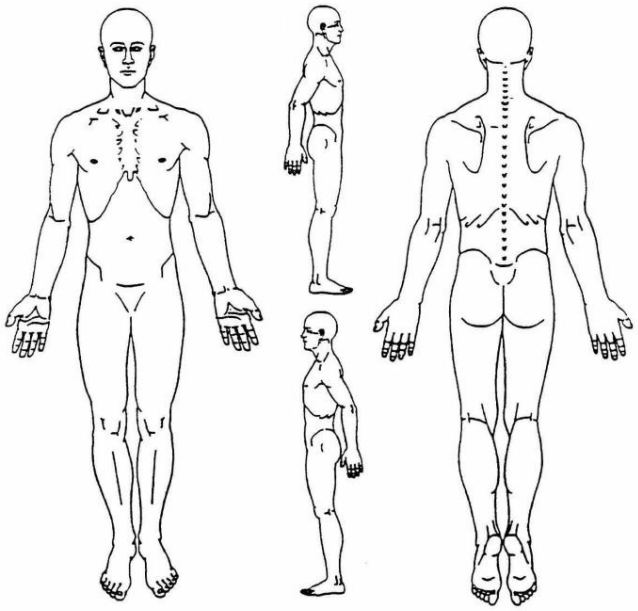
24. Are you working with an attorney?

○ Yes ○ No

If yes please include firm name and phone number.

AREAS OF CONCERN

25. What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern.



26. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

_____

27. What treatment, if any, have you received? Choose all that apply.

	Yes	No
Hospitalization		
Surgery		
Acupuncture		
Chiropractic care		
Injection therapy		
Massage		
Naturopathic medicine		
Physical therapy		
Primary care physician visit		
Over-the-counter medications		
Prescribed medications		
Heat or cold therapy		
None		
Other		

If other, specify:

28. Are there any additional symptoms? Choose all that apply.

	Yes	No
Breathing difficulty		
Muscle spasm		
Chest pain		
Numbness and tingling		
Depression		
Rib pain		
Facial pain		
Stomach pain		
Genital pain		
Headaches		
Tightness		
Soreness		
Shock		
Dizziness		
Sleeping difficulty		
Stress		
Gluteal pain		
Irritability		
Stunned		
Tiredness		
Loss of appetite		
Anxiety		
Low energy		
None		
Other		

If other, specify:

29. Have your symptoms changed since the onset of your concern? Choose all that apply.

	Yes	No
Improved daily functioning at home/work		
Shown no change in daily functioning at home/work		
Deteriorated daily functioning at home/work		
Symptoms have exacerbated		
Symptoms have disappeared		
Elicited more pain		
Elicited more stiffness		

30. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

☐ 0 (no pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (servere pain)

How often do you feel this discomfort?

☐ Constant (7-100%) ☐ Frequent (51-75%) ☐ Occasionally(26-50%) ☐ Intermittently (0-25%)

31. Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

32. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other, specify:

33. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

_____

34. Have other health care provider(s) performed tests related to this condition?

- ○ X-Ray
- ○ MRI
- ○ CT Scan
- ○ Other
- ○ None

Please specify year:

_____

35. Have you ever had any previous episodes of this condition?

- ○ Yes
- ○ No

If Yes, specify:

_____

36. Do you have an additional condition?

- ○ Yes
- ○ No

If Yes, specify:

_____

37. Approximate date this condition began (exact date not required)

_____

What caused this condition?

What is your primary area of concern? We will ask about additional complaints after we gather information about this first area of concern. Describe primary body area of concern:

38. Are you pregnant?

☐ Yes ☐ No

If you are pregnant, how many weeks are you?

Who is your OBGYN?

CURRENT HEALTH

39. Are you currently taking any medications?

○ Yes ○ No

40. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		

41. Other than the condition(s) already shared, do you have any additional health concerns?

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

42. If you have answered yes to any of the above, please share this info with your doctor.

43. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

PERSONAL AND FAMILY HISTORY

44.

	Yes	No
Have you had any surgical procedures?		
Do you have a past history of accidents or trauma?		
\Are there any past illnesses or conditions we should be aware of?		
Do you have past or current illnesses?		

45. If you have answered yes to any of the above, please explain what procedure

_____

WORK, SOCIAL, HABITS

46. Current work habits - Choose all that apply.

☐ Permanently fully disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition
☐ Full-time (20-40+ hours/week) ☐ Part-time (1-19 hours/week) ☐ Retired ☐ Student ☐ Homemaker
☐ Unemployed

47. Personal social habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

48. Present exercise habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

49. Diet and nutrition habits

	Yes	No
Vegan or vegetarian		
Daily supplements		
Other		