Center of Chiropractic Neurology New Patient Intake Paperwork

1 Patient Information

Legal Name: (Last) _____ (First) _____ (Middle Initial) _____

Email: _____ Primary Phone: _____ ☐Home ☐Cell ☐Work

Address: _____ City: _____

State: _____ Zip: _____ Sex ☐M ☐F Age: _____ Birth Date: _____

Social Security # or DL #_____ ☐Married ☐Single ☐Partnered ☐Widowed

☐Children How many: _____

Occupation: _____ Patient Employer/School: _____

Address: _____ Phone: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you? Event you attended? _____

Values: *Please list your interests in order of importance from 1 to 7 (1= most important)*

Family _____ Financial _____ Social _____ Physical _____ Mental _____ Spiritual _____ Work _____

2 Payment/Insurance Information

Who is financially responsible for this account: ☐Self-Pay or ☐Other (Name): _____

If 'Other', what is relationship to patient? _____

If insured, who is the main subscriber/policy holder? _____

Birth Date: _____ Phone: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

☐Health Insurer Insurance Co Name: _____ ID # _____ Group # _____

☐Government Program Name: _____ ID # _____

Is this policy associated with an ☐HSA ☐FSA ☐HRA? ☐Yes ☐No

Is patient covered by additional/ secondary insurance? ☐Yes ☐No

Insurance Co. Name: _____ ID #_____ Group # _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date, 2) consent to treatment by CCN, 3) assign to CCN, any healthcare insurance or reimbursement benefits to which you are entitled for the ca CCN (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to CCN releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt o CCN's Notice of Privacy Practices.

_____ _____

Printed name of Patient, Parent, Guardian or Personal Representative

Signature of Patient, Parent, Guardian or Personal Representative

Relationship: _____ Date: _____

3 Medications

1) _____

2) _____

3) _____

Pharmacy Name: _____

Pharmacy Phone: (_____) _____

☐None

Vitamins/Supplements

1) _____

2) _____

3) _____

4) _____

☐Daily ☐Weekly ☐Occasionally

☐None

Allergies

1) _____

2) _____

3) _____

4) _____

How often do they occur?

_____

☐None

4 Family History

Autoimmune Dis.	☐Yes ☐No	Diabetes	☐Yes ☐No	Migraines	☐Yes ☐No	☐Other	_____
Bleeding Disorder	☐Yes ☐No	Heart Disease	☐Yes ☐No	Osteoporosis	☐Yes ☐No		
Clotting Disorder	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Stroke	☐Yes ☐No		
Cancer	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Disease	☐Yes ☐No		

5 Medical History

Name and address of other doctor(s):

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____

MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐ Yes ☐ No	Chemical Depend./ Alchoholism	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	**Pinched Nerve**	☐ Yes ☐ No
Allergies	☐ Yes ☐ No			**Herniated Disk**	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No	**Clotting Disorder**	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	STD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Autoimmune Dis.	☐ Yes ☐ No	**Epilepsy/Seizure Dis.**	☐ Yes ☐ No	**MS**	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____ ☐ Other _____

6 Motor Vehicle Accident ☐ Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of Accident (MO - YR): ____ - ____

Impact: ☐ Front ☐ Rear ☐ Side/Passenger ☐ Side/Driver ☐ Seat Belt ☐ Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

Chiropractic Care Description:

7 Motor Vehicle Accident ☐ Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of Accident (MO - YR): ____ - ____

Impact: ☐ Front ☐ Rear ☐ Side/Passenger ☐ Side/Driver ☐ Seat Belt ☐ Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

Chiropractic Care Description:

8 Physical & Trauma Information

Please indicate any physical and/or trauma occurences below, making sure to note any minor injuries as well by checking 'Yes'. Please describe when applicable.

Work Activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Retired _____

Work Injuries: ☐ Yes ☐ No If yes: _____

Sport Activities: _____

Sport Injuries: ☐ Yes ☐ No If yes: _____

Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy _____

Home Injuries: ☐ Yes ☐ No If yes: _____

Habits: ☐ Nicotine ☐ Alcohol ☐ Coffee/Caffeine Drinks ☐ High Stress Level ☐ None

How Much? _____ How Often? ☐ Daily ☐ Weekly ☐ Occasionally

Falls: ☐ Yes ☐ No If yes: _____

Head Injuries: ☐ Yes ☐ No If yes: _____

Dislocations: ☐ Yes ☐ No If yes: _____

Broken Bones: ☐ Yes ☐ No If yes: _____

Surgeries: ☐ Yes ☐ No If yes: _____

Your Birth Delivery: ☐ Vaginal ☐ Cesarean ☐ Unknown

Complications: ☐ Breech ☐ Fetal Distress ☐ CPD ☐ Placenta Previa ☐ Premature ☐ Umbilical Cord ☐ Meconium Aspiration ☐ None

9 Primary Complaint

*Please note **ONE** complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.*

☐ Denied

Primary complaint: _____

Please describe the condition: _____

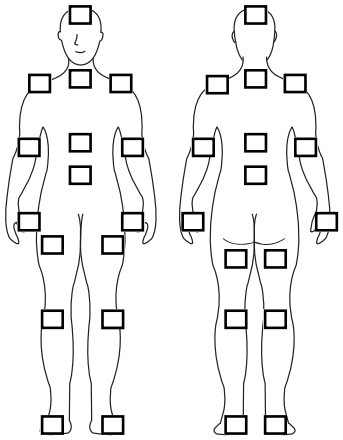
When did your symptoms first appear? _____

Most recent occurence date: _____

What do you think caused this problem? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain ...at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

...at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

(please circle) ...at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other _____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

10 Additional Complaint I

*Please note **ONE** complaint in the following section. The Additional Complaint I is any other problem/complaint you may be experiencing that you would like the office to be made aware.*

☐ Denied

Additional complaint _____

Please describe the condition _____

How often does it occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain travel from one location to another? From where to where? _____

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other _____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

11 Additional Complaint II

*Please note **ONE** complaint in the following section. The Additional Complaint II is any other problem/complaint you may be experiencing that you would like the office to be made aware.*

☐ Denied

Additional complaint _____

Please describe the condition _____

How often does it occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain travel from one location to another? From where to where? _____

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other _____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

12 **Is there anything else you would like the Doctor of Chiropractic to know?**

FOR OFFICE USE ONLY

Clinical Comments:

Examiner's Name: _____ Examiner's Signature: _____ Date: _____

Physician/Provider Name: _____ Physician/Provider Signature: _____ Date: _____