NEW PATIENT
INTAKE • HEALTH PROFILE • HISTORY

Date ___/___/_____

PATIENT INFORMATION *(all fields required)*

Name: _____ Age: _____ Date of Birth: _____

Address: _____ SSN: _____ Sex: ☐ Male ☐ Female

City: _____ State: _____ Zip: _____ Employer/School: _____

Cell Phone: (____)_____ Occupation: _____

Home Phone: (____)_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Email: _____ ☐ Separated ☐ Divorced ☐ Partnered for _____ years

IN CASE OF EMERGENCY, CONTACT: Spouse's Name: _____

Name: _____ Relationship: _____ Spouse's Employer: _____

Cell: (____)_____ Home: (____)_____ Whom may we thank for referring you? _____

MEDICATIONS/SUPPLEMENTS/ALLERGIES:

_____ _____ _____

_____ _____ _____

CONSENT TO EVALUATE AND TREAT A MINOR

I, _____ being the parent or legal guardian of _____, have read and fully understand the below terms of acceptance and hereby grant permission for my child to receive chiropractic care at Danvers Family Chiropractic.

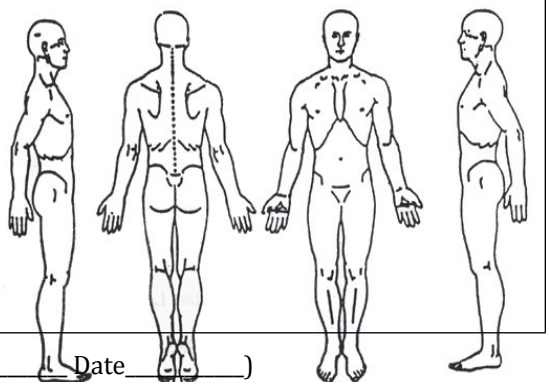
_____ _____

LEGAL GUARDIAN SIGNATURE DATE

PATIENT HEALTH CONCERNS

Health Concern: List according to severity.	Rate on Scale from: 0-10 0-None 10-Most	When did it start? Year/Month	Is it getting better or worse?	What makes it better & what makes it worse?	Sharp? Dull? Burning? Numb? Achy? Tingling? Weakness?	Intermittent (I) or Constant? (C)
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____

Place an "X" on the diagram where you are experiencing discomfort:



Does this interfere with: ☐ Work ☐ Sleep ☐Recreation ☐ Daily Routine

Have you sought other healthcare providers for this? Yes/No

☐ Chiropractic (Dr _____ Date_____)

☐ Medications (Dr _____ Date_____)

☐ Surgery (Dr _____ Date_____)

☐ Physical Therapy (Dr _____ Date_____)

☐ Other (Dr _____ Date_____)

PATIENT HEALTH HISTORY

Family Physician: _____ May we contact this physician? Yes / No

Have you received Chiropractic care before? Y / N Name: _____ Dates: _____ to _____

Have you had SPINAL X-Rays/ MRI's/ CT's? Y / N Type/Date: _____

Check "Yes" or "No" to indicate if you have OR have ever had any of the following:

Aids/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arth	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine HA's	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Seizure	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Dys	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Dz	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Dz	☐ Yes ☐ No
Chemical		High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking/Previous	Packs/Day _____ Date Quit _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress	Reason _____

ILLNESS-WELLNESS CONTINUUM (Circle the number that best represents your overall health today.)

Pre-Mature Death ⟵ **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** ⟶ **High-Level Wellness**

PREGNANCY

Are you currently pregnant? ☐ No ☐ Yes, I am due: _____

Number of past pregnancies: _____

Children's ages: Child #1 _____ Child #2 _____ Child #3 _____ Child #4 _____

INJURIES/SURGERIES/ACCIDENTS you have had:	**Description**	**Date(s)**
Accidents:	_____	_____
Falls:	_____	_____
Surgeries:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____

FAMILY HEALTH HISTORY

SOME HEALTH PROBLEMS COMMONLY OCCUR IN MULTIPLE MEMBERS OF THE SAME FAMILY. THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING A COMPREHENSIVE REVIEW OF YOUR FAMILY'S CURRENT AND PAST HEALTH HISTORY. (PLACE CHECKMARKS FOR MULTIPLE CHILDREN.)

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
THYROID PROBLEMS					
TMJ					
*NOT ABOVE (LIST BELOW)					

_____ _____

PRINT PATIENT NAME DATE

INSURANCE INFORMATION

Insurance Co: _____ Insurance Phone #: _____

ID #: _____ Name of Policy Holder: _____

Group #: _____ SSN: _____ Policy Holder DOB: _____

Secondary Insurance Co: _____ Secondary Insurance Phone #: _____

ID #: _____ Employer: _____

Group #: _____ Relationship to Patient (if not self): _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Danvers Family Chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

PATIENT or LEGAL GUARDIAN SIGNATURE RELATIONSHIP to PATIENT