Koster Family Chiropractic

# GENERAL NEW PATIENT INTAKE

**Dear Patient:**

**Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!**

## PERSONAL INFORMATION:

Name _____Social Security # _____

Address _____City _____ State _____ Zip _____

Home Telephone # _____ Work Telephone # _____ Cell # _____

E- Mail Address _____ Best form of contact _____

Appointment Reminders: TEXT or EMAIL For text reminders, who is your cell phone service provider? _____

How soon before your appointment would you like your reminder? 1 HOUR 2 HOURS 1 DAY Other: _____

Age _____ Birth date __/__/____ Employer _____ Occupation _____

# Children ____ Marital Status M / S / W / D Spouse's Name _____ Referred by _____

Emergency Contact _____Phone #:_____

## HEALTH INFORMATION:

Have you had previous chiropractic care? YES NO What is your primary reason for today's visit? _____

_____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What aggravates your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your Work ☐ Sleep ☐ Daily Routine ☐ Other: _____

How long has it been since you really felt good? _____

Other doctors who treated this condition _____

Please list **All** medications you currently take**:** _____

_____

Please list **All** Vitamins/Herbs you now take: _____

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe _____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years

Describe _____

## FAMILY HEALTH HISTORY

Information about you immediate family members, Brothers, Sisters, Parents, Grandparents will give us a better understanding of your total health picture.

**RELATIONSHIP** **PRESENT & PAST HEALTH PROBLEMS**

_____

_____

_____

**PAST MEDICAL HISTORY –** Please list **All** surgeries, pregnancies, illnesses, childhood diseases, etc. Please use back of page if more space is needed.

_____

_____

**SOCIAL HISTORY** – Example: Smoking, Drinking, current level of exercise and activity..... How much / How long?

_____

## INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

If yes, Name of Company _____

Name of Policy Holder_____D.O.B____/____ /_____

Are you covered by Medicare? ☐ Yes ☐ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

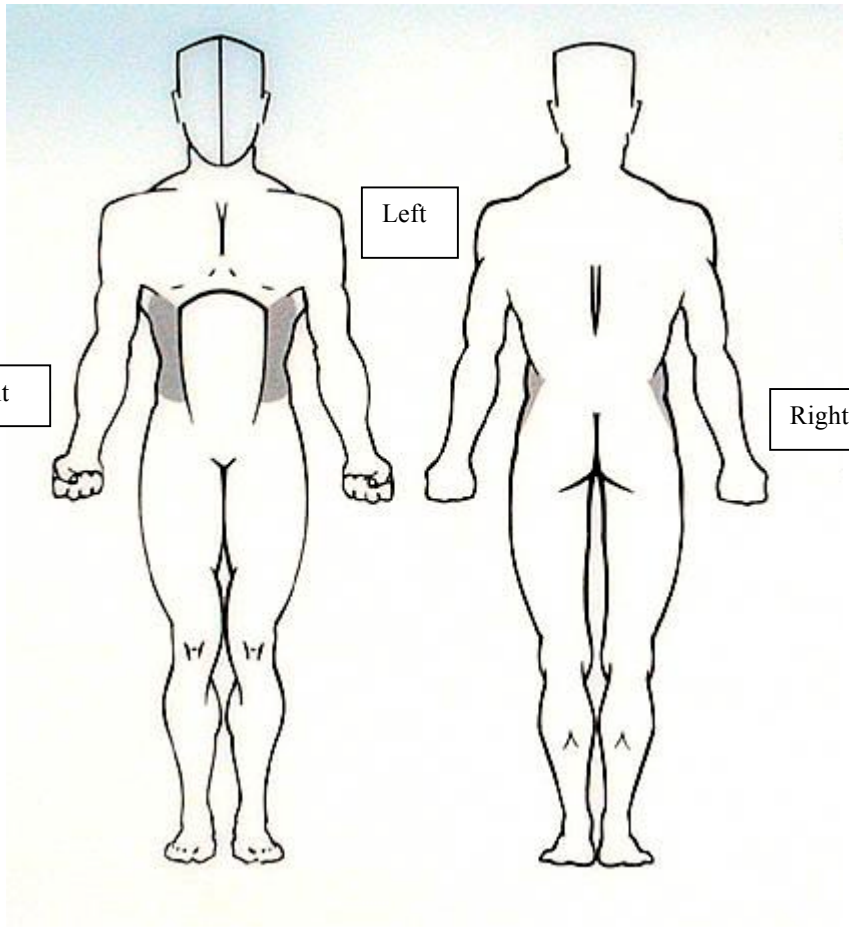
Patient's Signature _____ Date _____

**Name:** _____ **Date:** _____

Mark the areas on your body where you feel the following sensations:

Pain **XXX** Numbness **OOO** Pins and Needles **---**
Burning **BBB** Stabbing **///** Other **+++**

Front



Back

Left

Right

Right

## Visual Analog Scale

Indicate the severity of your pain by marking an "X" at the appropriate point on pain line
0 is "NO PAIN" and 10 is the "WORST PAIN" you have ever felt.

How bad is your neck pain now?

0 — 10

How bad is your back pain now?

0 — 10

How bad is your arm pain now?

0 — 10

How bad is your leg pain now?

0 — 10