

Fralick Chiropractic New Patient Intake Information

1

Patient Information

Patient Name (Last Name) _____ (First Name) _____ (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
 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 _____

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Payment/Insurance Information

Who is responsible for this account? _____
 Self-Pay Name(s) of responsible parties: _____
 Relationship to patient: _____
 Government Program Name: _____ ID # _____
 Health Insurer Insurance Co Name: _____ ID # _____ Group # _____
 Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____
 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 Chiro One, 3) assign to Chiro One, any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by Chiro One, authorize their payment directly to Chiro One, and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to Chiro One (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to Chiro One releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of Chiro One's Notice of Privacy Practices.

 Printed name of Patient, Parent, Guardian or Personal Representative _____
 Signature of Patient, Parent, Guardian or Personal Representative
 Relationship: _____ Date: _____

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Medications

Vitamins/Supplements

Allergies

1) _____ 2) _____ 3) _____ Pharmacy Name: _____ Pharmacy Phone: (____) _____ <input type="checkbox"/> None	1) _____ 2) _____ 3) _____ 4) _____ <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> None	1) _____ 2) _____ 3) _____ 4) _____ How often do they occur? _____ <input type="checkbox"/> None
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Family History

Autoimmune Dis. <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other _____
Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Clotting Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	

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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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemical Depend./	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheum. Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Dis.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizure Dis.	<input type="checkbox"/> Yes <input type="checkbox"/> No	MS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many weeks?	_____			<input type="checkbox"/> Other	_____

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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:

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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:

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Physical & Trauma Information

Please indicate any physical and/or trauma occurrences 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: Smoking 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: _____

Birth Delivery: Vaginal Cesarean Complications: Breech Fetal Distress CPD Placenta Previa
 Umbilical Cord Meconium Aspiration

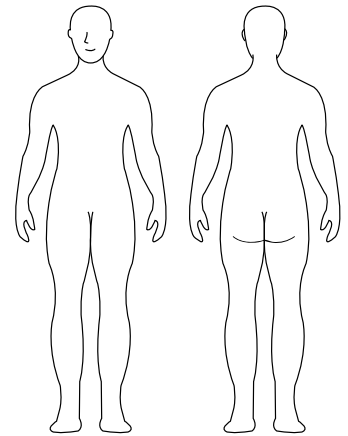
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Primary Complaint

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 occurrence 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: _____

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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: _____

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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: _____

