Patient Intake

Pt. ID:_____ Ext. ID:____ Case#:_____ New Spring Chiropractic, Palm Coast, FL

Legal Name: First_____ Middle: _____Last _____Preferred:_____

Date of Birth:_____/_____/_____ Gender:☐M ☐F Marital Status: ☐S☐M ☐D ☐W SSN: _____-_____-_____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ ☐ I wish to be opted-out of text reminders.

Email _____ Do you wish to receive email appointment reminders? ☐Y ☐N

Whom may we thank for referring you?_____ Employed? ☐Y ☐N Employer:_____

Please read and sign:

- I hereby understand that any and all payments are due at time of service and any returned check and/or any NSF(Non-Sufficient Funds) are subject to a $25 fee and will be charge to me directly
- I authorize the release of information by any media pertinent to my case to any insurance company, adjuster, or attorney involved in my case, and verification of employment. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible to New Spring Chiropractic for all charges incurred and not covered by the insurance, workers compensation and any collection, thirty-three and one third per cent (33 1/3%) attorney fees, interest and/or cost accrued in trying to collect this account
- I understand any balances over 30 days are subject to accrued interest of 1.5 percent per month
- I have read all information in this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.
- I agree to notify staff immediately if my contact number changes and will not hold New Spring Chiropractic responsible for text messages that are sent to the wrong number because of lack of notification.

Patient Signature_____ □Parent (if minor) Date: _____

Reason For Seeking Care (please mark diagram below where pain is present)

1:_____What event caused the problem? _____
Date problem began: _____/_____/_____ What makes it worse? _____
What makes it better? _____ Quality: □Aching □Stabbing □ Burning □Pins and Needles
Please rate your condition on a scale of 0 to 10. **0 = no pain 10 = excruciating pain 0 1 2 3 4 5 6 7 8 9 10**

Is the condition worst during certain times of day?☐**Y** ☐**N Time:** ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**During Night**

2:_____What event caused the problem? _____
Date problem began: _____/_____/_____ What makes it worse? _____
What makes it better? _____ Quality: □Aching □Stabbing □ Burning □Pins and Needles
Please rate your condition on a scale of 0 to 10. **0 = no pain 10 = excruciating pain 0 1 2 3 4 5 6 7 8 9 10**

Is the condition worst during certain times of day?☐**Y** ☐**N Time:** ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**During Night**

3:_____What event caused the problem? _____
Date problem began: _____/_____/_____ What makes it worse? _____
What makes it better? _____ Quality: □Aching □Stabbing □ Burning □Pins and Needles
Please rate your condition on a scale of 0 to 10. **0 = no pain 10 = excruciating pain 0 1 2 3 4 5 6 7 8 9 10**

Is the condition worst during certain times of day?☐**Y** ☐**N Time:** ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**During Night**

Do you have any numbness or radiating pain? ☐Y☐N
If yes, please describe:_____

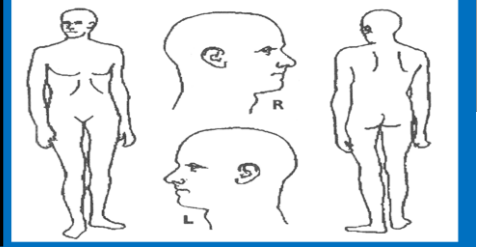
Mark if you are experiencing: ☐Dizziness ☐Visual Disturbances

Does this affect your:☐Work ☐Dressing ☐Bathing ☐Sleep
Primary Care Physician: _____

Are you pregnant?

□**Y** □**N**

Due Date:_____



REVIEW OF SYSTEMS- Mark Any of These Problems you have NOW or in the PAST– Mark NO if none apply

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing				**Ear, Nose and Throat**	Past	Present	No
Pace Maker								Difficulty Swallowing			
Jaw Pain				**Eyes**	Past	Present	No	Dizziness			
Irregular Heartbeat				Glaucoma				Hearing Loss			
Swelling of legs				Double Vision				Sore Throat			
Genitourinary	Past	Present	No	Blurred Vision				Nosebleeds			
Kidney Disease				**Psychiatric**	Past	Present	No	Bleeding Gums			
Burning Urination				Depression				Sinus Infections			
Frequent Urination				Anxiety				**Gastrointestinal**			No
Blood in Urine				Stress				Gall Bladder Problems			
Kidney Stones								Bowel Problems			
Lower Side Pain				**Endocrine**	Past	Present	No	Constipation			
Neurologic	Past	Present	No	Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**	Past	Present	No	**Musculoskeletal**			No
Pinched Nerves				Hepatitis				Gout			
Parkinson's				Blood Clots				Arthritis			
Carpal Tunnel				Cancer				Joint Stiffness			
Vertigo				Bruising				Muscle Weakness			
Constitutional	Past	Present	No	Bleeding				Osteoporosis			
Weight Loss/Gain				Fever, Chills				Broken Bones			
Low Energy Level				Sweating				Joints Replaced			

GENERAL HEALTH HISTORY

Please list any surgeries and approximate date: _____

Medications: ☐None ☐Yes: Start Date Brand Name Dosage Condition

_____

_____

_____

FAMILY HISTORY

Mother's side: ☐**Cancer** ☐ **Diabetes** ☐**Heart Disease** ☐**Mental Health** ☐**Stroke** ☐**Headaches** ☐**Other:**_____

Father's side: ☐**Cancer** ☐ **Diabetes** ☐**Heart Disease** ☐**Mental Health** ☐**Stroke** ☐**Headaches** ☐**Other:**_____

Any other blood relatives with similar conditions?_____

SOCIAL HISTORY (check all that are true) ☐ Sexually active ☐ Currently use tobacco ☐ Formerly used tobacco

☐Balanced diet ☐Eat fast food ☐Take vitamins ☐Exercise regularly ☐Sleep well ☐Sleep poor ☐Drink alcohol ☐ Use Drugs