NEW PATIENT INTAKE FORM

Peterson Chiropractic
Align Yourself with Health

Date: _____

PERSONAL INFORMATION

Name: _____

Address: _____

_____

Primary Phone: _____

Work Phone: _____

Email: _____

Date of Birth: _____

Social Security Number: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ Student

EMPLOYER INFORMATION

Name: _____

Address: _____

_____

Occupation: _____

Job Description: _____

_____

_____

EMERGENCY CONTACT

Name: _____

Relationship to Patient: _____

Primary Phone: _____

Work Phone: _____

How did you hear about our office?

☐ Social Media ☐ Google Search ☐ Referral

Other: _____

MEDICAL HISTORY

Medical Conditions: (Check all that apply to you)

☐ Arthritis ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ Hypertension ☐ Psychiatric Illness
☐ Skin Disorder ☐ Stroke ☐ Pregnant

Other: _____

Surgeries: (Check all that apply to you)

☐ Appendectomy ☐ Cardiovascular ☐ Cervical spine
☐ Hysterectomy ☐ Joint Replacement ☐ Prostate
☐ Lumbar spine ☐ Gall Bladder ☐ Brain
☐ Shoulder ☐ Thoracic spine ☐ Knee
☐ Carpal Tunnel ☐ Gastro-intestinal ☐ Uro-genital
☐ Hernia

Other:

Allergies: (Check all that apply to you)

☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose
☐ Peanuts ☐ Soy ☐ Sulfites
☐ Wheat/Glutens

Other: _____

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Alcohol use:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

Family History: (Check all that apply)

☐ Arthritis ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ Hypertension ☐ Psychiatric Illness
☐ Skin Disorder ☐ Stroke

Other: _____

SYMPTOMS

Indicate on the body diagram where you are experiencing the following symptoms:

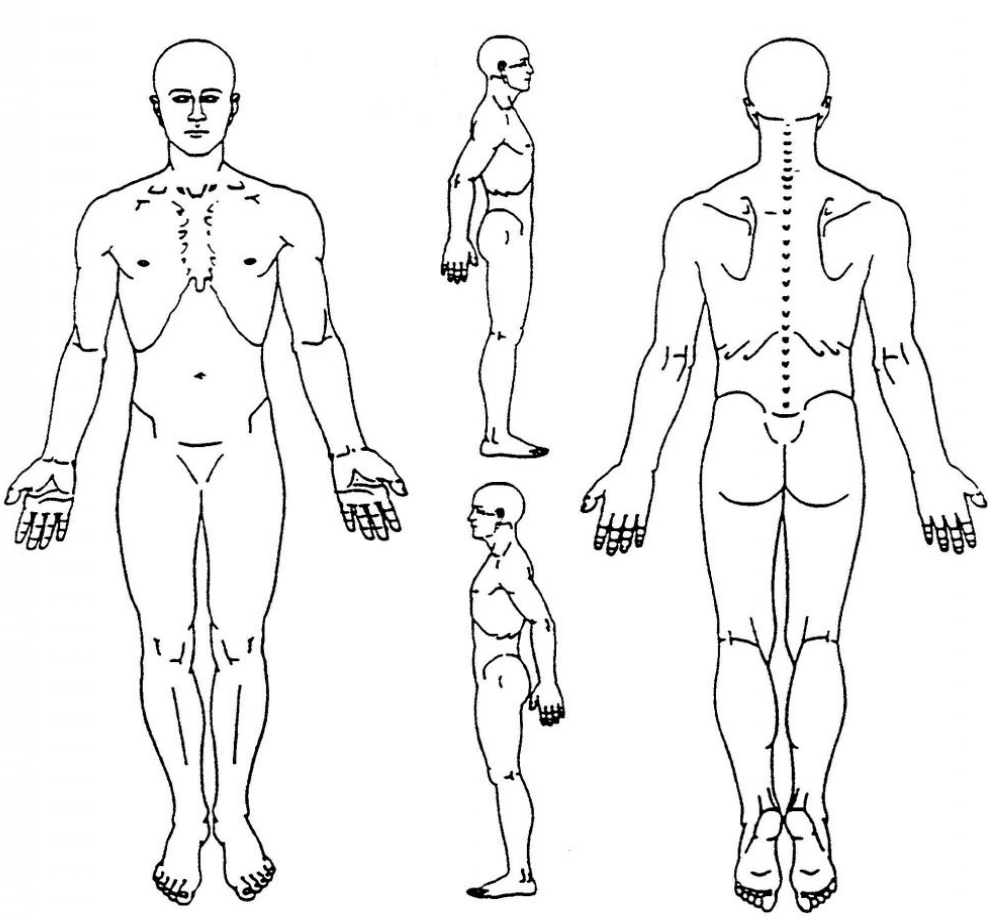
N = Numbness

B = Burning

S = Stabbing

T = Tingling

A = Dull Ache



When did your symptoms begin?

_____

Symptoms started as a result of:

☐ Motor Vehicle Accident

☐ Work Related Accident

Other: _____

_____

Have you filed an injury report with your employer?

☐ Yes ☐ No

Date: _____ Time: _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)

☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day)

☐ Intermittently (0-25% of the day)

Describe your symptoms in order of severity, starting with your worse symptom:

_____

_____

_____

_____

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and/or have been given the opportunity to review Peterson Chiropractic's Notice of HIPAA Privacy Practices for protected health information.

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

Consent to Treat a Minor (Minor's Printed Name): _____

Guardian / Spouse's Signature Authorizing Care: _____ Date: _____

Physician's Signature: _____ Date: _____