RESTORATION
CHIROPRACTIC
WELLNESS | ACCIDENTS | INJURIES | REHABILITATION

CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____ Date: _____

Sex: M F Date of Birth: _____ Age: _____

Home Address: _____ Apt. #_____

City: _____ State: _____ Zipcode: _____

Home Phone Number: _____ Cell Phone Number: _____

Social Security Number: _____ Email Address: _____

If Child, parent's/gaurdian's name: _____

Primary Care Physician: _____ Referred by: _____

Employer: _____ Work Number: _____

Emergency Contact Name: _____ Phone Number: _____

Would you like us to communicate to any other family members, Power of Attorney, or other individuals pertaining to your medical records, treatment plan, billing/insurance questions, appointments, etc.? If so please list below.

Name: _____

Relationship: _____

Do you allow us to release our medical records to a referring physician, primary care physician, or specialist if they request such to jointly treat your medical condition?

If so, PLEASE INITIAL HERE_____

Insurance Information

Insurance Company: _____ Policy Number: _____ Group Number: _____

What name is the policy under? _____ Relationship: SPOUSE PARENT OTHER

Patient HIPAA consent:

In each of our offices, we have our Notice of Privacy Practices published. The notice contains a Patient Right's section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change before signing this consent. If we change our Notice, you may obtain a revised copy by contacting our office.

You have a right to request how protected health information about you is used or disclosed for your treatment, payment, and health care operations. By signing this form, you consent to our use and disclosure of protected health information about our treatment, payment, and health operations. You have the right to revoke this consent, in writing, signed by you at any time; however, that does not affect any disclosures we have already made in reference with your prior consent. This consent is required so that Restoration Chiropractic is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

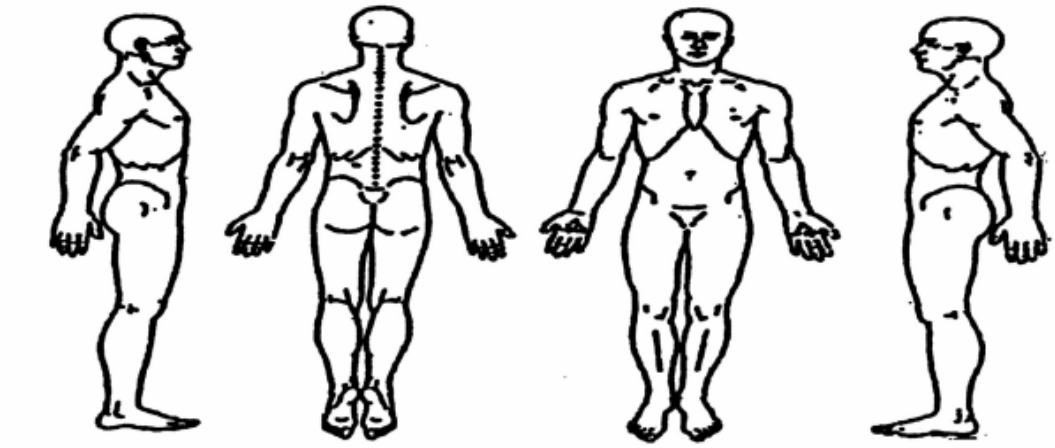
Patient Signature: _____ Staff Initials: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____

Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other: _____				

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today? _____

Restoration Chiropractic uses multiple forms of communication with our patients and, as such, we ask you provide the following information:

28. Cell Phone number? _____

29. Cell phone provider? _____

30. Primary email address? _____

Patient Signature_____ **Date:** _____

Dr.’s Notes: