New Patient Intake

Name:_____Date: _____

Mailing Address: _____

City_____State_____Zip _____

Email address: _____

Phone # (H)_____(W)_____(Other)_____

Date of Birth:_____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation:_____Employer: _____

Employer Address:_____Phone: _____

Emergency contact:_____Relation:_____

Phone #: (H)_____(W)_____(C) _____

How did you hear about our practice? _____

Please list any surgeries (with dates) and/or medical conditions (past & present) _____

_____

Please list any motor vehicle accidents, making sure to note any minor accidents or those that have taken place 5+ years ago:

_____

Family History: Please specify members of your family including extended family who have these illnesses.
Cancer:_____Thyroid Disease:_____
Heart Disease:_____High Blood Pressure: _____
Kidney Disease:_____Stroke: _____
Diabetes: _____Autoimmune Dis._____

Current Medications/Supplements		
Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time. Are You Pregnant? Yes ❑ No ❑

Patient Signature:_____Date: _____

Review of Systems

Name:_____Date of Birth:_____/____/____Date:_____/____/____

Please mark if you have experienced any of these symptoms within the ***last month****:*

Neurological
- ____ Migraines
- ____ Headaches
- ____ Slurring of speech
- ____ Ringing in ear
- ____ Dizziness
- ____ Pins/Needles Arms
- ____ Pins/Needles Legs
- ____ Cold Feet
- ____ Fainting
- ____ Fever

Ear/Nose/Throat
- ____ Altered taste/smell
- ____ Night Blindness
- ____ Sore Throat
- ____ Gingivitis
- ____ Nose bleeds
- ____ Blurred Vision
- ____ Light bothers eyes

Cardiovascular
- ____ Chest pain
- ____ Palpitations- racing heart beat
- ____ Swelling in hands/feet
- ____ Anemia

Respiratory
- ____ Recurrent respiratory infections
- ____ Asthma
- ____ Chest congestion
- ____ Wheezing
- ____ Frequent sneezing
- ____ Shortness of breath

Gastrointestinal
- ____ Stomach pains or cramping
- ____ Constipation
- ____ Reflux or heartburn
- ____ Bloating
- ____ Gas
- ____ Nausea or vomiting
- ____ Bowel/ bladder changes

Musculoskeletal
- ____ Joint pain
- ____ Arthritis
- ____ Chronic pain
- ____ Muscle aches
- ____ Neck pain
- ____ Back pain
- ____ Arm pain
- ____ Knee/leg pain
- ____ Night pain
- ____ Jaw problems

Skin
- ____ Eczema
- ____ Dermatitis
- ____ Excessive sweating
- ____ Rashes
- ____ Brittle nails
- ____ Hair loss
- ____ Increased bleeding
- ____ Easy bruising
- ____ Numbness/tingling
- ____ Cold sweats

Genitourinary
- ____ Uterine fibroids
- ____ Ovarian cysts
- ____ Cancer (breast, ovarian, prostate,uterine)
- ____ Prostate problems

Emotional/Mental
- ____ Depression
- ____ Anxiety
- ____ Mood swings
- ____ Irritability
- ____ Memory loss
- ____ Confusion
- ____ Nervousness

Energy
- ____ Fatigue
- ____ Hyperactivity
- ____ Restlessness
- ____ Insomnia
- ____ Decreased libido
- ____ Stress
- ____ Tension

Weight
- ____ Decreased appetite
- ____ Weight gain
- ____ Inability to lose weight
- ____ Food cravings
- ____ Binge eating
- ____ Water retention
- ____ Sudden weight loss

Allergies
- ____ Hives
- ____ Runny nose
- ____ Itchy/Watery eyes
- ____ Congestion

____ **None of the above**

Primary Complaint

What is your chief complaint today? _____

When is the most recent occurrence date?_____

When did these conditions begin? _____

What do you think caused the problem?_____

Please rate your pain (0- no pain, 10- severe pain)

- **At its worst**_____
- **At its best**_____
- **Right now**_____

Type of pain (please circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling

Does the pain travel? From where to where?_____

How often do you have this pain? Constantly (75%-100% of the time) Frequently (51%-75% of the time)

Occasionally (25%-50% of the time)

Pain worsens with:_____ **Pain improves with:**_____

Additional Complaint

Additional complaint:_____

When is the most recent occurrence date?_____

When did these conditions begin? _____

What do you think caused the problem?_____

Please rate your pain (0- no pain, 10- severe pain)

- **At its worst**_____
- **At its best**_____
- **Right now**_____

Type of pain (please circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling

Does the pain travel? From where to where?_____

How often do you have this pain? Constantly (75%-100% of the time) Frequently (51%-75% of the time)

Occasionally (25%-50% of the time)

Pain worsens with:_____ **Pain improves with:**_____

Functional Rating Index

In order to assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

Please circle the area(s) you are rating: **Headaches/ Neck Pain/ Shoulder Pain/ Middle Back Pain/ Lower Back Pain Hip Pain/ Knee Pain**

For each item below, please circle the one which most closely describes your condition ***at its worst***.

Pain Intensity

No pain	*Mild pain*	*Moderate pain*	*Severe pain*	*Worst possible pain*

Sleeping

Perfect sleep	*Mildly disturbed sleep*	*Moderately disturbed sleep*	*Greatly disturbed sleep*	*Totally disturbed sleep*

Personal Care (washing, dressing, etc.)

No pain with no restrictions	*Mild pain with no restrictions*	*Moderate pain; need to go slowly*	*Moderate pain; need some assistance*	*Severe pain; need 100% assistance*

Travel (Driving, etc.)

No pain on long trips	*Mild pain on long trips*	*Moderate pain on long trips*	*Moderate pain on short trips*	*Severe pain on short trips*

Work

Can do usual work plus unlimited extra work	*Can do usual work with no extra work*	*Can do 50% of usual work*	*Can do 25% of usual work*	*Cannot work*

Recreation

No pain	*Mild pain*	*Moderate pain*	*Severe pain*	*Worst possible pain*

Frequency of pain

No pain	*Occasional pain; 25% of the day*	*Intermittent pain; 50% of the day*	*Frequent pain; 75% of the day*	*Constant pain; 100% of the day*

Lifting

No pain with heavy weight	*Increased pain with heavy weight*	*Increased pain with moderate weight*	*Increased pain with light weight*	*Increased pain with any weight*

Walking

No pain with any distance	*Increased pain after 1 mile*	*Increased pain after 1/2 mile*	*Increased pain after 1/4 mile*	*Increased pain with all walking*

Standing

No pain after several hours	*Increased pain after several hours*	*Increased pain after 1 hour*	*Increased pain after 1/2 hour*	*Increased pain with any standing*

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient/Guardian Signature_____ **Date**_____

Authorization and Assignment

Please initial next to each line that applies to you. Thank you.

___**AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

___**ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

___**MEDICARE ASSIGNMENT (*if applicable*):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

___**ACKNOWLEDGEMMENT AND UNDERSTANDING:** I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Renew Health Center will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

Patient/Guardian Signature_____ **Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Renew Health Center. I understand and am informed that, while extremely rare, there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Name (please print)_____

Patient Signature_____ **Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____