

Confidential New Patient Intake Form**page 1 of 5****Welcome to Rees Chiropractic.**

In order to help us extend to you the best care possible,
please thoroughly complete and sign each of the next five pages.

This confidential information will be kept as a part of your permanent records.

**All of the information you provide is strictly confidential
 and will not be shared outside this office, unless you authorize it. THANK YOU.**

General Information and Consent to Examination:

Patient Name: _____ Date of Birth: _____
 SS#: _____ Age: _____
 Sex: **Male** **Female**
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Mobile Phone: _____
 Email address: _____ Work Phone: _____
 Occupation: _____ Employer: _____
 Primary Care Physician: _____ Location: _____ Phone: _____
 Have you been treated by a chiropractor before? **yes** **no** If yes, where and when? _____
 FEMALES ONLY: Are you pregnant? **yes** **no** Due Date: _____ OBGYN Name: _____
 Are you a Medicare patient? **yes** **no** Medicare #: _____
 EMERGENCY CONTACT: name: _____ phone: _____ relationship: _____

Who referred you to us? _____ May we use your name when thanking them? **yes** **no**
 How else have you heard about us? _____

→ Proper evaluation of your condition includes the appropriate history and physical evaluation. By signing below you attest that the information above is true and correct and also *give permission for the doctor and the staff to conduct necessary evaluation, including any provocative physical testing required.*

PATIENT SIGNATURE: _____ **DATE:** _____

If patient is a minor -

Print name of Parent or Guardian: _____

Signature of Parent or Guardian: _____ **DATE:** _____

Please continue providing vital information (over) →

Confidential New Patient Intake Form**page 2 of 5****Insurance Coverage (if applicable) and Assignment of Benefits:**

Primary Medical Insurance: **(Please present your insurance card when returning this form)**

Insurance Carrier: _____ Phone: _____

Policy Holder name: _____

Policy Holder's Date of Birth: _____ Relationship to patient: _____

Policy #: _____ Group #: _____

[If you are seeking treatment as a result of an *accident or injury sustained while on the job*- please also complete this section.]

Workers Compensation Injury:

Employer: _____ Phone: _____

Address: _____

Did you file an accident/injury report? **yes** **no** Date of report: _____

Date of accident/injury: _____ Time: _____

Workers Compensation Carrier: _____

Name of Adjuster: _____ Phone: _____

Claim #: _____

[If you are seeking treatment as a result of an *auto accident or other personal injury* - please also complete this section.]

Auto Accident/Insurance (or Personal Injury Claim): DATE OF ACCIDENT: _____

YOUR Auto Insurance Carrier: _____ Phone: _____

Name of Adjuster: _____ Claim #: _____

THEIR Auto Insurance Carrier: _____

THEIR name: _____ Phone: _____

Name of Adjuster: _____ Claim #: _____

→ **Assignment of Benefits:** I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to Rees Chiropractic. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

PATIENT SIGNATURE: _____ DATE: _____

Please continue providing vital information (over) →

Confidential New Patient Intake Form

Primary Complaints:

What is/are your main complaint(s) today? (check those that apply)

- Checkboxes for various symptoms: Dizziness/Vertigo, Headaches, Sciatica, Low Back Pain, etc.

OTHER, not covered above: _____

When did the condition begin? _____ What do you think caused it? _____

Is this condition interfering with your: [] work [] sleep [] daily routine [] other _____

Is this condition a work-related accident or incident? [] yes [] no

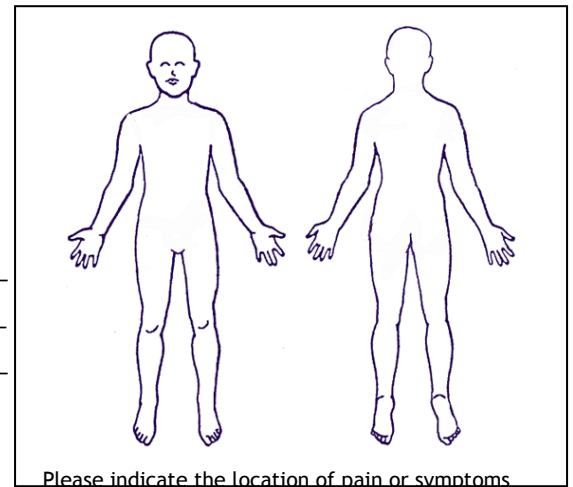
If yes, did you report it? [] yes [] no

Is this condition result of a motor vehicle accident? [] yes [] no

If yes, the date of accident: _____

What positions or activities: make it feel worse? _____

What positions or activities: make it feel better? _____



Please indicate the location of pain or symptoms

What have you tried that has not worked to alleviate your condition(s)? _____

Have you received treatment for this condition by other doctors or therapists? [] yes [] no

If so, by whom /when? _____

Have you had this or similar conditions in the past? [] yes [] no If yes, how long ago? _____

Since it began, is this condition generally: [] getting worse [] getting better [] staying the same

PATIENT SIGNATURE: _____

DATE: _____

Please continue providing vital information (over) ->

Confidential New Patient Intake Form **page 4 of 5**

Personal Health History:

→ To able to create an accurate clinical picture of your current state of health, we need your complete health history. Your responses will help determine in what ways chiropractic care can benefit you. Please check the **frequency** of all conditions you *currently have* or *have had* in the past. Thank you.

O= Occasional F= Frequent C= Constant

General

- O F C
 Dizziness
 Fainting
 Fatigue
 Fever
 Headache
 Neuralgia
 Night sweats
 Poor Posture
 Sciatica
 Sweats
 Involuntary Shaking
 Unexplained weight loss
 Fibromyalgia
 Poor diet

Gastrointestinal

- O F C
 Belching or gas
 Bloating
 Colitis
 Constipation
 Diarrhea
 Poor appetite
 Nausea
 Vomiting

Muscle / Joint

- O F C
 Arthritis
 Muscle weakness
 Neck stiffness
 Low back pain
 Back stiffness
 Mid back pain
 Joint locking
 Painful clicking
 Muscle spasm
 Neck pain
 Muscle tremors
 Bone Fracture

Pain or Numbness in:

- O F C
 Shoulders
 Arms
 Elbows
 Hands
 Hips
 Legs
 Knees
 Ankles
 Feet
 Heels
 Back
 Groin

Genitourinary

- O F C
 Blood in urine
 Frequent urination
 Incontinence
 Kidney infections
 Kidney stones
 Painful urination
 Difficulty urinating

Respiratory

- O F C
 Chest pain
 Chronic cough
 Difficulty breathing
 Wheezing

Ear, Eye, Nose, Throat

- O F C
 Asthma
 Colds
 Ear ache
 Ear discharge
 Ear infections
 Enlarged glands
 Eye pain
 Hoarseness
 Hearing loss
 Sinus infections

Cardiovascular

- O F C
 Ankle swelling
 Heart attack
 High blood pressure
 Low blood Pressure
 Poor circulation
 Rapid heartbeat
 Slow heartbeat

Please check any of the following conditions you have or have had:

- Addiction
 Anemia
 Back surgery
 Cancer _____
 Diabetes
 Eating disorder
 Eczema
 Epilepsy
 Gout
 Heart disease
 HIV / AIDS
 Multiple Sclerosis
 Pacemaker
 Stroke
 Sexually Transmitted Disease
 Hepatitis

Any other current or past health issues not covered above: _____

Please list any medications/drugs you are currently taking: _____

PATIENT SIGNATURE: _____

DATE: _____

Please continue providing vital information (over) →

Confidential New Patient Intake Form**page 5 of 5****Notice of Information Practice Policies:**

effective date: Jan 1, 2007

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include: emergency care, quality assurance activities, public health, research and law-enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and/or receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you via mail, email or telephone for appointment reminders, announcements, and to inform you about our practice and its staff. If we call and can't speak to you directly, we may leave a message if necessary; either with the person who answered the phone, or as a recorded message.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible office location for 6 months duration.

You may file a complaint about privacy violations by contacting our Office Manager.

→ *I have read and understand the aforementioned Rees Chiropractic Information Practices Policies.*

PATIENT SIGNATURE: _____

DATE: _____