THE HOLISTIC CENTER AT BRISTOL SQUARE
hands on healing

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# New Patient Intake

Name _____

Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Email _____

Date of Birth _____ Age_____ ☐ M ☐ F SSN _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Referred By _____

Emergency Contact _____

Relationship _____ Phone _____

## Employer

Employer _____

Business Phone _____

Type of Work _____

## Family

Name of Spouse _____

Spouse's Employer _____

Type of Work _____

Name / Age of Children _____

## Billing / Insurance

Responsible ☐ Self ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid

Insurance Name _____

Health Insurance # _____

## Current Health Condition

Purpose of Appointment _____

Other Doctors Seen? ☐ No ☐ Yes, Who?_____

When did this condition begin?_____

Has it occurred before? ☐ Yes ☐ No

Is condition ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other

Date / Time of Accident_____

Have you made a report of your accident to your employer? ☐ Yes ☐ No

Current Medications ☐ Nerve Medications ☐ Pain Killers / Muscle Relaxers ☐ Blood Pressure ☐ Insulin

Other _____

Do you wear a shoe lift? ☐ Yes ☐ No

Do you suffer from any condition other than that which you are now consulting us?

_____

## Past Health History

Surgery ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back ☐ Broken Bones

Describe _____

Major Accidents or Falls _____

Hospitalization (other than above) _____

Previous Chiropractic Care ☐ None Dr's Name & Date of Last Visit_____

Below is a list of diseases / conditions which may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall course of care. Check if you have had any of the following:

☐ Pneumonia
☐ Mumps
☐ Influenza
☐ Rheumatic Fever
☐ Small Pox
☐ Pleurisy
☐ Polio

☐ Chicken Pox
☐ Arthritis
☐ Tuberculosis
☐ Diabetes
☐ Epilepsy
☐ Whooping Cough
☐ Cancer

☐ Mental Disorder
☐ Anemia
☐ Heart Disease
☐ Lumbago
☐ Measles
☐ Thyroid
☐ Eczema

*Intake*
☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

**Have you had any of the following in the past 6 months?**

*Musculo-Skeletal*
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain

☐ Joint Pain / Stiffness
☐ Difficulty Chewing / Clicking Jaw
☐ Gas / Bloating After Meals

☐ Heartburn
☐ Black / Bloody Stool
☐ Colitis
☐ Walking Problems

☐ General Stiffness

*Females Only*

- ☐ Date of Last Period _____
- ☐ Pregnant
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain / Infection
- ☐ Breast Pain / Lumps

*Males Only*

- ☐ Prostate / Sexual Dysfunction

*Genito-Urinary*

- ☐ Bladder Trouble
- ☐ Discolored Urine

*Nervous System*

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ C-V-R Code
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

*General*

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

*EENT*

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

*Gastrointestinal*

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

**Why Chiropractic?**

People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Relief Care
- ☐ Chiropractic Care
- ☐ I would like the doctor to select the appropriate care for my condition.

Patient Signature _____ Date _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate throughout my spine. It is understood and agreed the amount paid the Doctor is for examination and x-rays only. The x-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he / she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature _____ Date _____

Guardian or Spouse's
Signature of Authorizing Care _____ Date _____