Patient Intake Form

Full Name: ____ Date: ______________________
First MI Last

Address: _____________________________ City:_____________________ State: ______ Zip: _______

How did you hear about us? ____

Social Security Number: ______________________ Email Address: ______________________________

Home Phone: __________________ Work Phone: __________________ Cell/Other: ___________________

Employer: ____ Occupation: _______________________

Business Address: __________________________ City: __________________ State: ______ Zip: _______

Spouse's Name: _____________________________________ Spouse's Date of Birth: _________________

Emergency Contact: _________________________ Emergency Contact Phone Number: ____________________

Payment Information

Person Responsible for Payment: ____

Social Security Number: _________________ Phone: ______________________ Date of Birth: ____________

Insurance Information

Do you have health insurance? _____ Yes _____ No	
Primary Insurance	**Secondary Insurance**
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:
Please have your insurance card and driver's license ready so they can be copied for the clinic's records	

Consent for Treatment

Assignment & Release - By signing below, I authorize Achieve Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Achieve Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Patient Signature ____ Date ______________

Parent/Legal Guardian Signature ____

Doctor's Initials __________

Health History

Patient Information:

Patient Name: ____ Date: ________________________

Do you exercise? □ Yes □ No Hours per week ___________What activity(s)? ____

____

List any surgeries or hospitalizations you have had along with the month and year for each:

____

____

List anything you are allergic to: ____

____

____

Family's Health History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

____

____

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Date of last menstrual period: _______ Are you pregnant or nursing? □ Yes □ No If yes, How many weeks? ______

Patient Signature ____ **Date:** ________________________

Parent/Legal Guardian Signature ____

Doctor's Notes: ____

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Doctor's Initials __________

Health History cont'd

Patient Name: ____ Date: ____________________

Please indicate if you have had the condition in the past or if you presently have the condition:

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments on your health history: ____

____

Patient Signature ____ **Date:** __________

Parent/Legal Guardian Signature ____

Doctor's Notes: ____

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Doctor's Initials __________

Complaint Information

Patient Name: ____ Date: _____________________

The following questions are about your area(s) of discomfort; we ask that you list these **one at a time** starting with your **main** area of concern, then answer the questions following, as it pertains to that area. There are following pages for **additional** complaints, list each one separately.

Describe the **Main** Complaint (I.e.: Neck Pain)

____

Are you here because of an accident? ___YES ___ NO; If Yes, please explain: ________________________________

When did your symptom start? ____

How did your symptom start? ____

Have you experienced this symptom in the past? ____

On a scale of 1-10, with 10 being most severe, circle your level of discomfort: 1 2 3 4 5 6 7 8 9 10

Describe your symptom? (circle all that apply)

Sharp Dull-Ache Numbing Burning Tingling Shooting Stiff Stabbing Throbbing Other ___________

How would you rate the Intensity of discomfort? (Circle one) Mild Moderate Severe

How often do you experience this symptom? (Circle one) Constantly Frequently Occasionally Intermittently

Since the onset of discomfort, is your symptom? (Circle one) Getting better Staying the same Getting worse

Does the discomfort radiate/travel? ______ If Yes, please describe where: _________________________________

____

What helps to improve your complaint? (Circle all that apply) Rest Cold Pack Heat Stretching Exercise Massage

OTC Medication Prescription Medicine Other ________

Patient Signature ____ **Date:** __________________

Parent/Legal Guardian Signature ____

Doctor's Notes: ____

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Doctor's Initials __________

Complaint Information

Patient Name: ____ Date: __________________

Additional Complaint

Describe your **additional** complaint (I.e.: Neck Pain)

____

Are you here because of an accident? ___YES ___ NO; If Yes, please explain: __________________________

When did your symptom start? ____

How did your symptom start? ____

Have you experienced this symptom in the past? ____

On a scale of 1-10, with 10 being most severe, circle your level of discomfort: 1 2 3 4 5 6 7 8 9 10

Describe your symptom? (circle all that apply)

Sharp Dull-Ache Numbing Burning Tingling Shooting Stiff Stabbing Throbbing Other __________

How would you rate the Intensity of discomfort? (Circle one) Mild Moderate Severe

How often do you experience this symptom? (Circle one) Constantly Frequently Occasionally Intermittently

Since the onset of discomfort, is your symptom? (Circle one) Getting better Staying the same Getting worse

Does the discomfort radiate/travel? _______ If Yes, please describe where: ____________________________

____

What helps to improve your complaint? (Circle all that apply) Rest Cold Pack Heat Stretching Exercise Massage

OTC Medication Prescription Medicine Other __________

Patient Signature ____ **Date:** ______________

Parent/Legal Guardian Signature ____

Doctor's Notes: ____

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Complaint Information

Patient Name: ____ Date: ___________________

Additional Complaint

Describe your **additional** complaint (I.e.: Neck Pain)

____

Are you here because of an accident? ___YES ___ NO; If Yes, please explain: ____________________________

When did your symptom start? ____

How did your symptom start? ____

Have you experienced this symptom in the past? ____

On a scale of 1-10, with 10 being most severe, circle your level of discomfort: 1 2 3 4 5 6 7 8 9 10

Describe your symptom? (circle all that apply)

Sharp Dull-Ache Numbing Burning Tingling Shooting Stiff Stabbing Throbbing Other ___________

How would you rate the Intensity of discomfort? (Circle one) Mild Moderate Severe

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Since the onset of discomfort, is your symptom? (Circle one) Getting better Staying the same Getting worse

Does the discomfort radiate/travel? _______ If Yes, please describe where: ___________________________

____

What helps to improve your complaint? (Circle all that apply) Rest Cold Pack Heat Stretching Exercise Massage

OTC Medication Prescription Medicine Other _________

Patient Signature ____ **Date:** ______________

Parent/Legal Guardian Signature ____

Doctor's Notes: ____

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Doctor's Initials _________

History of Treatment

Patient Name: ____ Date: _________________

Have you seen a chiropractor? ___Yes _____ No If Yes, when was your last visit? ______________________________

Have you received treatment for these symptoms?_____ If yes, indicate when you were last seen and by whom:

____

Primary care physician: _____________________________________ Phone: ____________________

Date last seen: _______________ May we update them on your condition? ____Yes ____ No

Do you have a medical referral? _________ If yes, indicate name and type of referring medical provider or person:

____

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____

Patient Signature ____ **Date:** _________________

Parent/Legal Guardian Signature ____

If patient is a minor, print their name here ____

Doctor's Notes: ____

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Doctor's Initials __________

Achieve Chiropractic
4001 Coliseum Drive, Suite 315 • Hampton, VA 23666 • 757-224-9223, Fax 757-224-9293

Electronic Health Records Intake Form

In compliance with requirements for the government EHR Incentive Program

First Name: ______________________________ Middle Initial: _______ Last Name: ____

Age: ______ Birth Date: ____ /____ / _____ Gender(Circle One): Male Female Height: ________ Weight: _________

Preferred Language: ___________________ I am (circle one) Single Married Divorced Widowed Separated

Smoking Status (Circle One): Every Day Smoker Occasional Smoker Former Smoker Never Smoked

CMS requires providers to report both Race and Ethnicity

Race (Circle One): American Indian Alaskan Native Asian Black/African American Native Hawaiian
Pacific Islander White/Caucasian Other: ____________________________ Decline to Answer

Ethnicity (Circle One): Hispanic/Latino Not Hispanic/Latino Decline to Answer

Are you currently taking medications? If yes, please list below and include regularly used over the counter medications & supplements:

Medication Name:	**Dosage & Frequency:**(i.e.- 5mg once a day, etc)

Do you have any medication Allergies? If yes, please list below:

Medication Name	**Reaction**	**Onset Date**	**Additional Comments**

Patient Signature ____ **Date:** _______________________

Parent/Legal Guardian Signature ____

Doctor's Initials ___________