New Patient Intake Form ***Today's Date:*** _____/_____/_____

Title: ❑ *Mr.* ❑ *Mrs.* ❑ *Ms.* ❑ *Miss* ❑ *Dr.* *Date of Birth* ____/____/_____ *Age:* ____

First Name _____ *MI* ____ *Last Name* _____

Address _____

City _____ *State* _____ *Zip Code* _____

Home Phone (_____) _____-_____ *Work Phone* (_____) _____-_____

Cell Phone (_____) _____-_____ *Email* _____

Authorization to: ❑ ***Call*** (❑ *Cell* ❑ *Home* ❑ *Work*) ❑***Text*** ❑ ***Email*** ❑ *Don't leave messages*

Gender: ❑ *Male* ❑ *Female* *SSN:* _____-_____-_____

(If you want to use your insurance)

Marital Status : ❑ *Single* ❑ *Married* ❑ *Other* _____

# of Children _____ *Ages* ____/____/____/____/____/____/____/____

Employment: ❑ *Employed* ❑ *Self* ❑ *Unemployed* ❑ *FT Student* ❑ *PT Student* ❑ *Retired*

Employer _____

Your Occupation _____

Spouse Information

First Name _____ *MI* ____ *Last Name* _____

Home Phone (_____) _____-_____ *Work Phone* (_____) _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact ❑ *Same as Spouse*

Contact Name _____ *Relationship to Patient* _____

Contact Home Phone (_____) _____-_____ *Cell Phone* (_____) _____-_____

How did you hear about our office?

❑ *Patient:* _____ ❑ *NewsPaper:* _____
❑ *Marketing material:* _____ ❑ *Other:* _____

Is your condition the result of: ❑ *Car accident* ❑ *Work accident* ❑ *Other* _____

Date of accident : ___/____/_____ *Do you or will you have a report?* ❑ *Yes* ❑ *No*

Do you have insurance coverage? ❑ *Yes* ❑ *No* ❑ *Personal injury case* ❑ *Workers Comp*

❑ *BCBS GA* ❑ *Aetna* ❑ *Cigna* ❑ *United Health* ❑ *Humana* ❑ *Railroad Medicare*
❑ *Medicare* ❑ *Medicaid* ❑ *Other:* _____ *(Car, Work, Private, etc.)*

Insurance Plan : _____ *Primary insured :* ❑ *Self* ❑ _____

Group #: _____ *CPID #:* _____

Insurance address: _____

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Crisis Care, Critical Transition and Lifestyle Care Plans. Details of these plans will be discussed with you during your Chiropractic Report. Please choose one of the following fee options:

❑ **Regular Fees:** If you have health insurance that covers chiropractic and choose to use it, you will be charged the regular fees. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you and you will be expected to pay your balance within 30 days. Please note that most insurance companies do not cover Critical Transition or Lifestyle Care.

❑ **Time of Service Discounted Fees:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you will be eligible for the time of service (TOS) discounted fees. You may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts. In order to be compliant, you will have to sign up for a PCD membership, and pay the $37 per year per family fee associated, in order to participate in the TOS discounted fees

If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims. Once the claim is complete, you can begin to pay the Time of Service discounted fees again.

I, (name) _____ have read and I understand the above policies.

I have selected the fee option that applies to me.

_____

Patient signature Date

Medical Conditions:	❑ No Issues		
❑ Arthritis	❑ Fibromyalgia	❑ Diabetes	❑ Other
❑ Hypertension	❑ Cancer	❑ Heart Disease	
❑ Fibromyalgia	❑ Psychiatric Illness	❑ Stroke	
❑ Asthma	❑ Skin Disorder	❑ Osteoporosis	

Allergies:	❑ No Issues		
❑ Mold	❑ Seasonal	❑ Milk or Lactose	❑ Animal
❑ Chemical	❑ Sulfites	❑ Wheat/Glutens	❑ Other x

Surgeries:	❑ No Issues		
❑ Appendectomy	❑ Cardiovascular	❑ Cervical spine	❑ Hysterectomy
❑ Joint Replacement	❑ Prostate	❑ Lumbar spine	❑ Gall Bladder
❑ Brain	❑ Shoulder	❑ Thoracic spine	❑ Knee
❑ Carpal Tunnel	❑ Gastro-intestinal	❑ Uro-genital	❑ Hernia
❑ Breast Augmentation	❑ Other		

Family History	❑ No Issues	❑ No Issues
❑ Arthritis	❑ Parent	❑ Sibling
❑ Cancer	❑ Parent	❑ Sibling
❑ Diabetes	❑ Parent	❑ Sibling
❑ Heart Disease	❑ Parent	❑ Sibling
❑ Hypertension	❑ Parent	❑ Sibling
❑ Stroke	❑ Parent	❑ Sibling
❑ Thyroid	❑ Parent	❑ Sibling

Cardiovascular				**Respiratory**				**Allergic/Immunologic**			
❑ No Issues	**Past**	**Present**		❑ No Issues	**Past**	**Present**		❑ No Issues	**Past**	**Present**	
Poor Circulation	❑	❑		*Asthma*	❑	❑		*Hives*	❑	❑	
Hypertension	❑	❑		*Tuberculosis*	❑	❑		*Immune Disorder*	❑	❑	
Aortic Aneurism	❑	❑		*Short Breath*	❑	❑		*HIV/AIDS*	❑	❑	
Heart Disease	❑	❑		*Emphysema*	❑	❑		*Allergy Shots*	❑	❑	
Heart Attack	❑	❑		*Cold/Flu*	❑	❑		*Cortisone Use*	❑	❑	
Chest Pain	❑	❑		*Cough*	❑	❑					
High Cholesterol	❑	❑		*Wheezing*	❑	❑					
Pace Maker	❑	❑						**Ear, Nose and Throat**			
Jaw Pain	❑	❑		**Eyes**				❑ No Issues	**Past**	**Present**	
Irregular Heartbeat	❑	❑		❑ No Issues	**Past**	**Present**		*Difficulty Swallowing*	❑	❑	
Swelling of legs	❑	❑		*Glaucoma*	❑	❑		*Dizziness*	❑	❑	
				Double Vision	❑	❑		*Hearing Loss*	❑	❑	
Genitourinary				*Blurred Vision*	❑	❑		*Sore Throat*	❑	❑	
❑ No Issues	**Past**	**Present**						*Nosebleeds*	❑	❑	
Kidney Disease	❑	❑		**Psychiatric**				*Bleeding Gums*	❑	❑	
Burning Urination	❑	❑		❑ No Issues	**Past**	**Present**		*Sinus Infections*	❑	❑	
Frequent Urination	❑	❑		*Depression*	❑	❑					
Blood in Urine	❑	❑		*Anxiety*	❑	❑		**Gastrointestinal**			
Kidney Stones	❑	❑		*Stress*	❑	❑		❑ No Issues	**Past**	**Present**	
Lower Side Pain	❑	❑						*Gall Bladder Problems*	❑	❑	
				Endocrine				*Bowel Problems*	❑	❑	
Neurologic				❑ No Issues	**Past**	**Present**		*Constipation*	❑	❑	
❑ No Issues	**Past**	**Present**		*Thyroid*	❑	❑		*Liver Problems*	❑	❑	
Stroke	❑	❑		*Diabetes*	❑	❑		*Ulcers*	❑	❑	
Seizures	❑	❑		*Hair Loss*	❑	❑		*Diarrhea*	❑	❑	
Head Injury	❑	❑		*Menopausal*	❑	❑		*Nausea/Vomiting*	❑	❑	
Brain Aneurysm	❑	❑		*PMS*	❑	❑		*Bloody Stools*	❑	❑	
Numbness	❑	❑						*Poor Appetite*	❑	❑	
Severe Headaches	❑	❑		**Hematologic**							
Pinched Nerves	❑	❑		❑ No Issues	**Past**	**Present**		**Musculoskeletal**			
Parkinson's	❑	❑		*Hepatitis*	❑	❑		❑ No Issues	**Past**	**Present**	
Carpal Tunnel	❑	❑		*Blood Clots*	❑	❑		*Gout*	❑	❑	
Vertigo	❑	❑		*Cancer*	❑	❑		*Arthritis*	❑	❑	
				Bruising	❑	❑		*Joint Stiffness*	❑	❑	
Constitutional				*Bleeding*	❑	❑		*Muscle Weakness*	❑	❑	
❑ No Issues	**Past**	**Present**		*Fever, Chills*	❑	❑		*Osteoporosis*	❑	❑	
				Sweating	❑	❑		*Broken Bones*	❑	❑	
Weight Loss/Gain	❑	❑		*Varicose Vein*	❑	❑		*Joints Replaced*	❑	❑	
Low Energy Level	❑	❑						*Neck Pain*	❑	❑	
Difficulty Sleeping	❑	❑						*Low Back Pain*	❑	❑	
								Upper Back Pain	❑	❑	

Social History:	Frequency	Frequency	
❑ Caffeine use	❑ Occasional	❑ Often	❑ never
❑ Drink Alcohol	❑ Occasional	❑ Often	❑ never
❑ Exercise	❑ Occasional	❑ Often	❑ never
❑ Drink Water	❑ More than 64 oz/day	❑ Less than 64 oz/day	❑ never
❑ Cigarettes	❑ More than 1 pack/day	❑ Less than 1 pack/day	❑ never
❑ Sleep	❑ Over 8 hours/night	❑ Less than 8 hours/night	❑ Insomnia
❑ Other			

Occupational Activities			
❑ Administration	❑ Business Owner	❑ Clerical/Secretary	❑ Computer User
❑ Heavy Equipment operator	❑ Daycare/Childcare	❑ Construction	❑ Health Care
❑ Food Service Industry	❑ Medium Manual Labor	❑ Manufacturing	❑ Home Services
❑ Heavy Manual Labor	❑ Light Manual Labor	❑ Executive/Legal	❑ Housekeeper
❑ Other			

Other Information you would like to include:

What is your **primary reason** for consulting today? _____

When did your symptoms begin? _____

How did your symptoms begin? _____

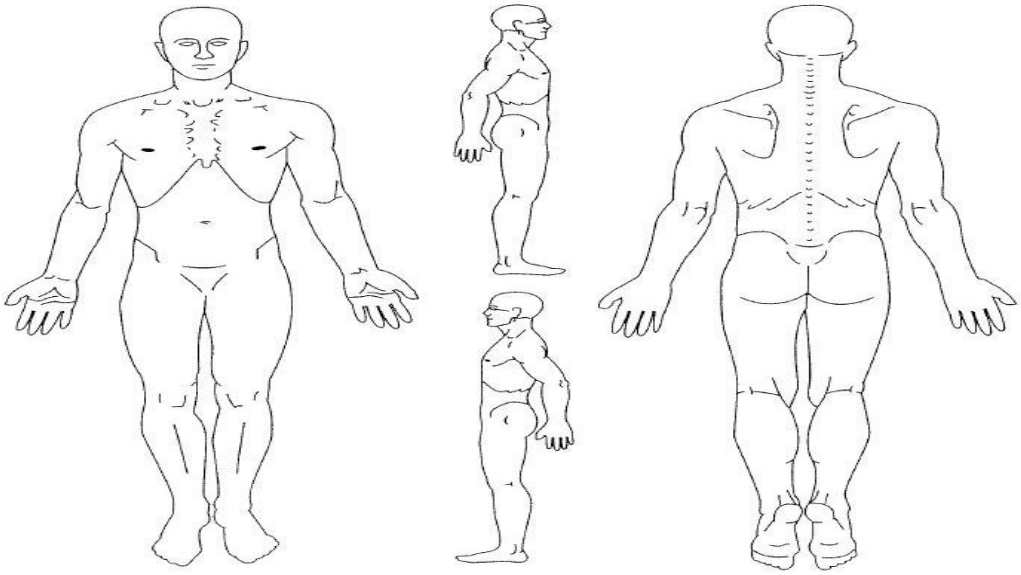
_____

What describes the nature of your symptoms?

❑ Sharp	❑ Ache	❑ Numb	❑ Shooting
❑ Burning	❑ Tingling	❑ Throbbing	❑ Other _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity: (Circle)

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? ❑ Yes ❑ No If Yes, please list: _____

How often do you experience your symptoms? (Select one)

❑ Constantly (76-100% of the day)	❑ Frequently (51-75% of the day)	❑ Occasionally (26-50% of the day)	❑ Intermittently (0-25% of the day)

I _____, certify that this information is exact to the best of my knowledge.

Date : ___/___/_____