VERITY CHIROPRACTIC

Patient Intake
Please Complete All Fields

Date: _____ **Patient #** _____

Name: (Mr. Mrs. Ms. Dr.) _____

Address: _____City _____State _____Zip_____

Home Phone (_____)_____Cell(_____)_____Fax(_____)_____

Date of Birth_____/_____/_____ Age_____ Social Security #_____-_____-_____

Marital Status: M S D W Number of Children:_____ Email Address_____

Occupation: _____ Employer_____

Employer's Address: _____Phone #:(_____)_____

Spouse Name: _____ Social Security #_____-_____-_____

Spouse's Date of Birth:_____

Occupation: _____Employer_____

Employer's Address_____ Phone #:(_____)_____

Emergency Contact: _____ Phone #:(_____)_____

How did you hear about our office?_____

Please check any and all insurance that may be applicable in this case.

__Major Medical __Medicare __Secondary __Medicaid __ Auto Accident __ Other

Name of Primary Insurance Company_____

Address_____ Phone #:(_____)_____

ID#: _____ Group #: _____

Name of Secondary Insurance Company (if any)_____

Address_____ Phone #:(_____)_____

ID#: _____ Group #:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts.

Affidavit Signature:_____Date:_____

Dr. Initials: _____

VERITY CHIROPRACTIC

Name:_____(Cont'd)

Primary Care Physician Name :_____ Phone:(_____)_____

Date of Last Physical _____

May Rodgers Stein Chiropractic Center contact your Primary Care Physician on your behalf if necessary?_____

Please describe the purpose of this appointment _____

Number of doctors seen for this condition 1 2 3 4 5 6 7 8 9 10

What is your major symptom? _____

What does this prevent you from doing or enjoying?_____

If this is a recurrence, when was the first time you noticed this problem?_____

How did it originally occur?_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? _____

How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only ___ Other___ please describe_____

How long does it last? All Day _____ Few Hours _____ Minutes _____

Have you had X-rays taken? (Circle) low back_date___/___/_____ neck_date___/___/_____chest_date ___/___/_____

Other_____ Date ___/___/_____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Other _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

Please rate your pain using the following scale: (0=no pain, 10 = worst possible pain):

Current pain intensity: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Average pain intensity: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Worst pain intensity: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Education level

□ Grade 8 or less
□ Partial high school
□ High school graduate
□ Some college
□ College graduate
□ Masters or Higher

Employment Status

□ Paid full time
□ Paid part time
□ Homemaker
□ Student
□ Unemployed
□ Retired
□ Other

Main Work Activity

□ Heavy labor
□ Light labor
□ Mostly sitting at desk
□ Mostly standing
□ Mostly walking/moving about
□ Driving or operating vehicle

Job Satisfaction

□ Really like my job
□ Like my job
□ No opinion
□ Dislike my job
□ Really dislike my job

Do you smoke?_____ If yes, how many packs per day._____

Do you drink alcohol? _____ If yes, amount _____

Do you drink caffeine? _____ If yes, amount _____

Doctor:_____

Dr. Initials: _____

VERITY CHIROPRACTIC

Name:_____(Cont'd)

PATIENT HISTORY

PERSONAL HISTORY

Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ Others_____

Unusual Childhood Diseases:_____

Adult Illnesses or Conditions: _____

Surgeries/Hospitalizations:_____

Fractures:_____

Please list all Medications/ Supplements that you are currently using and the reason(s) you are using them:

_____

_____

_____

Are you allergic to any drugs or medications?_____

Do you have allergies to any of the following? Food____ Airborne ____ Lotions/oils/perfumes ____ Seasonal ____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you?

Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Heart Attack/Stroke	_____	Thyroid problems	_____
Sexually transmitted disease	_____	Heart murmur	_____
Heart valve problems	_____		

Dr. Initials: _____

VERITY CHIROPRACTIC

Name:_____(Cont'd)

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age[ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Stroke						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

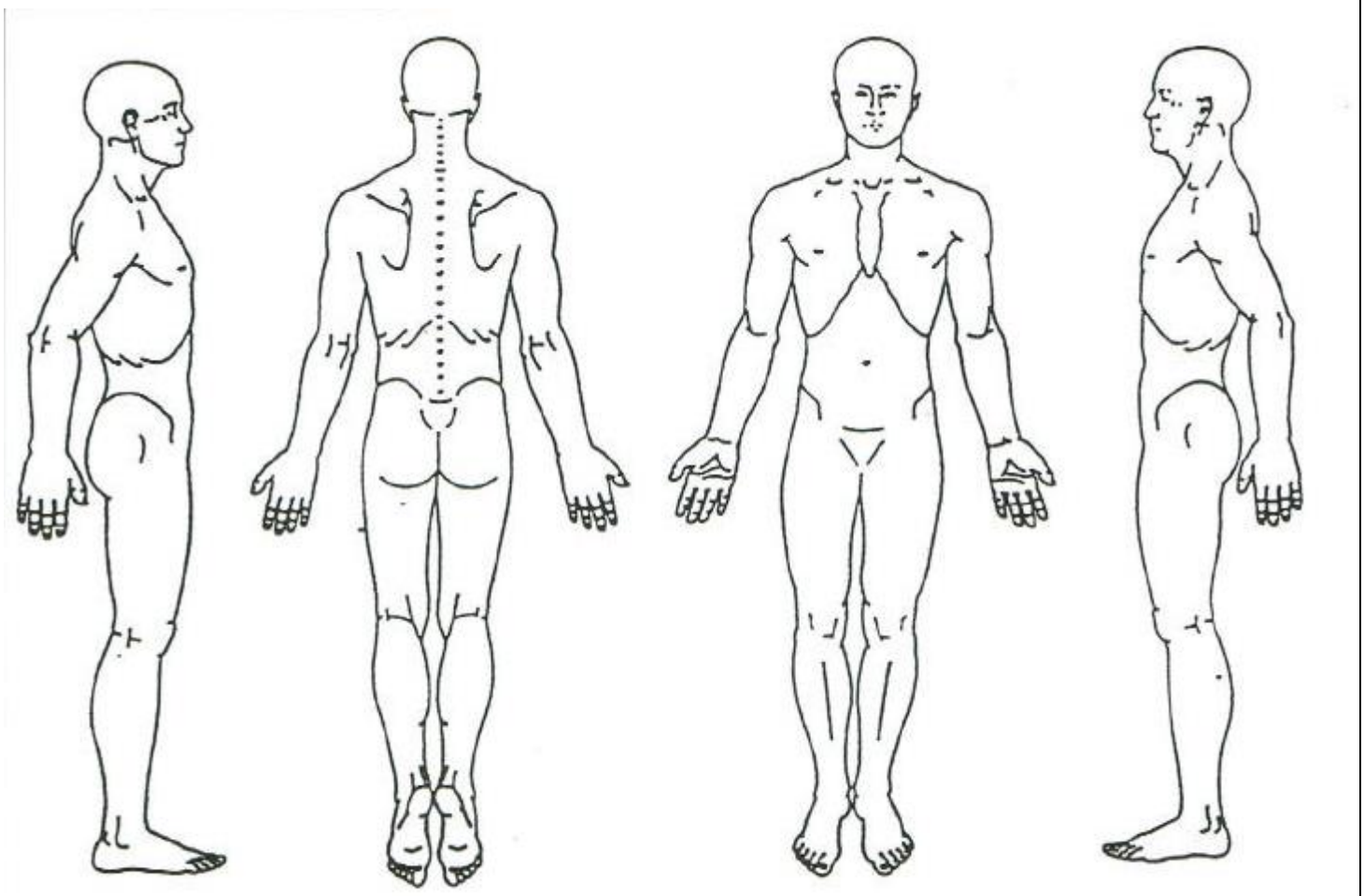
Dr. Initials: _____

VERITY CHIROPRACTIC

Name: _____(Cont'd)

Please use the following key to accurately mark the areas in which you feel the described sensations. Include all affected areas. .

Dull Ache NNN **Stabbing/Cutting //////** **Burning XXX** **Pinching PPPP**
Cramping SSSSS **Numbness -- -- -- -- --** **Tingling (pins & needles) OOOO**



Using the scale 0-100, with 0=no pain and 100= worst possible pain, please write the number indicating your pain level_____.

Affidavit Signature:_____ Date:_____

Dr. Initials: _____

VERITY CHIROPRACTIC

Dr. Initials: _____