NEW PATIENT INTAKE FORM

BALLARD CHIROPRACTIC

PATIENT DEMOGRAHICS

Today's Date:_____

Name: _____ **Birth Date:**_____ **Age:** _____ □Male □Female

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Marital Status: S M D W **Do you have Insurance:** Yes or No **Insurance Company:** _____

Employer: _____ **Occupation:** _____ **Years at Position:** _____

Spouse's Name: _____ **Spouse's Birth Date:** _____

Name & Number of Emergency Contact: _____ **Relationship:** _____

PATIENT HISTORY

Primary Complaint: _____ **Secondary:** _____ **Third:** _____

Have you been treated for this condition before: _____ If yes, by whom: _____

Date of Last Physical Exam: _____

Name of Previous Chiropractor: _____ **Last Chiropractic Exam:** _____

List All Surgeries: _____

List any Health Conditions in last year: _____

Medications you're currently taking: _____

Have you suffered from:

Dizziness: Yes or No	**Backache:** Yes or No	**Heart Issues:** Yes or No	**Nervousness:** Yes or No
Cancer: Yes or No	**Arthritis:** Yes or No	**Headaches:** Yes or No	**Sinus Issues:** Yes or No
Asthma: Yes or No	**Anemia:** Yes or No	**Neuritis:** Yes or No	**Digestive Issues:** Yes or No
Diabetes: Yes or No	**Numbness:** Yes or No	**Tuberculosis:** Yes or No	

Patient's Signature: _____ **Date:** _____

Guardian/Spouse Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

NEW PATIENT INTAKE FORM

BALLARD CHIROPRACTIC

STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby assign and authorize my benefits for services rendered to me to be paid directly to Ballard Chiropractic. I understand that verification of insurance benefits is not a guarantee that benefits will be paid.

I further understand that my health insurance company may not cover all or part of the medical services rendered and that I am financially responsible for and agree to pay all charges not paid by my health care coverage. Ballard Chiropractic only files insurance for patients who have policies that we are contracted with.

I authorize the release of medical information as may be required to process the claims for payment of the medical services rendered.

Patient's Signature:_____ **Date:**_____

X-RAYS/IMAGING STUDIES (Females only)

□ The first day of my last menstrual cycle was on _____

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient's Signature:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICE

Our Notice of Privacy Practice provides information about how we may use and release protected health information about you. You have the right to view the notice before signing this form. If we change the privacy notices, you may obtain a copy by request.

By signing this form, you consent to our use and release of protected health information as described in our notice.

Patient's Signature:_____ **Date:**_____

Doctor Signature:_____ **Date:**_____

Consultation & Patient History

BALLARD CHIROPRACTIC

Today's Date:_____

Name: _____ **Age:** _____ □ **MALE** □ **FEMALE** **Marital Status: S M D W**
Height: _____ **Weight:** _____

Employer at time of Injury: _____ **Currently:** _____

□ **Unemployed Due to Injury: Yes or No**

Type of work: □ **Office/Clerical** □ **Light Labor** □ **Moderate Labor** □ **Hard Labor** □ **Other:** _____

Did you lose any days of work? □ **Yes** □ **No** **How many?** _____

Explain in details activity at work: _____

_____

HABITS

Smoke: □ **No** _____**Packs/day** _____**Years** **Alcohol:** □ **Never** □ **Social** □ **Light** □ **Moderate** □ **Heavy**

Physical Activity Level: □ **Sedentary** □ **Light** □ **Moderate** □ **Heavy** _____

INJURY HISTORY

Onset date:_____ **Etiology:** □ **Sudden** □ **Gradual** □ **Unknown**

Can you remember what brought your pain on: _____

_____

Site of Injury: □ **Head** □ **Neck** □ **Upper/Mid Back** □ **Low Back**

□ **Shoulder** _____ □ **Upper Extremity** _____ □ **Lower Extremity** _____

Have you seen any other health care professional for this condition? □ **Yes** □ **No (if yes, continue below)**

Emergency Dept Date: _____ □ Exam □ Radiographs □ Cervical □ Thoracic □ Lumbar □ Other_____

Results: _____ Lab Work: □ Yes □ No

RX at Hospital: □ Injection for _____ □ Pills for _____

□ Cervical Collar □ Ice Other TX: _____ Scrip RX:_____

Follow up Instructions: □ Yes □ None Notes:_____

Dr. _____ Date first seen:_____ Specialty:_____

Referred by: _____ Currently Treating? □ Yes □ No

TX type:_____ TX Frequency:_____ TX Duration:_____

Did TX help? □ Yes □ No Special Test:_____ Any disabilities? □ Yes □ No
Describe:_____

Referred to:_____

Notes:_____

Consultation & Patient History

BALLARD CHIROPRACTIC

CURRENT SYMPTOMS

FIRST CONDITION: _____ **Onset Date:** _____ □ **Sudden** □ **Gradual**

□ **Left** □ **Right** □ **Both** **Severity:** **NONE 1 2 3 4 5 6 7 8 9 10 WORST**

Increased Symptoms: □ Standing □ Sitting □ Lying Down □ Bending □ Lifting □ Twisting

□ All Movements □ Other: _____

Duration: □ Frequent □ Intermittent □ Constant

Decreased Symptoms: □ Standing □ Sitting □ Lying Down □ Medicine □ Other: _____

Radiate: □ Left □ Right □ Back □ Tingling □ Numbness

□ _____ □ _____ □ _____

Quality: □ Stiff □ Ache □ Throb □ Burning □ Tight □ Stabbing □ Sharp □ Dull □ Other: _____

SECOND CONDITION: _____ **Onset Date:** _____ □ **Sudden** □ **Gradual**

□ **Left** □ **Right** □ **Both** **Severity:** **NONE 1 2 3 4 5 6 7 8 9 10 WORST**

Increased Symptoms: □ Standing □ Sitting □ Lying Down □ Bending □ Lifting □ Twisting

□ All Movements □ Other: _____

Duration: □ Frequent □ Intermittent □ Constant

Decreased Symptoms: □ Standing □ Sitting □ Lying Down □ Medicine □ Other: _____

Radiate: □ Left □ Right □ Back □ Tingling □ Numbness

□ _____ □ _____ □ _____

Quality: □ Stiff □ Ache □ Throb □ Burning □ Tight □ Stabbing □ Sharp □ Dull □ Other: _____

THIRD CONDITION: _____ **Onset Date:** _____ □ **Sudden** □ **Gradual**

□ **Left** □ **Right** □ **Both** **Severity:** **NONE 1 2 3 4 5 6 7 8 9 10 WORST**

Increased Symptoms: □ Standing □ Sitting □ Lying Down □ Bending □ Lifting □ Twisting

□ All Movements □ Other: _____

Duration: □ Frequent □ Intermittent □ Constant

Decreased Symptoms: □ Standing □ Sitting □ Lying Down □ Medicine □ Other: _____

Radiate: □ Left □ Right □ Back □ Tingling □ Numbness

□ _____ □ _____ □ _____

Quality: □ Stiff □ Ache □ Throb □ Burning □ Tight □ Stabbing □ Sharp □ Dull □ Other: _____

Consultation & Patient History

BALLARD CHIROPRACTIC

Daily Activity Affected by Injury:

□ Sleep □ Standing/Sitting □ Walking □ Personal Care □ Travel □ Work □ Lifting □ Recreation

PAST MEDICAL HISTORY

Fractures: _____

Surgeries: _____

Serious Illness: _____

Worker's Comp. Injuries: _____

Other Personal or Sport Injuries: _____

Others: _____

PATIENT SERVICES:

□ **Exam**

□ **Radiographs**

□ **Cervical:** □ A/P □ Lateral □ APOM □ Flex/Ext □ Obliques

□ **Thoracic:** □ A/P □ Lateral

□ **Lumbar:** □ A/P □ Lateral

□ **Other:** _____

□ **Other:** _____

□ **Therapeutic Modalities:**

□ **Heat/Cold (area)** _____

□ **EMS (area)** _____

□ **US (area)** _____

□ **Other** _____

□ **Other** _____

REQUEST RECORDS:

□ **Radiographs**

From: _____ From: _____

□ **Medical Records**

From: _____ From: _____

□ **Other**

From: _____ From: _____

REFERRALS:

□ To: _____ For: _____

□ To: _____ For: _____

□ To: _____ For: _____

DISABILITY: _____

From: _____ Until: _____

RESTRICTIONS: _____

From: _____ Until: _____