Date _____

NEW PATIENT INTAKE

All questions must be answered completely

Name _____ Date of Birth _____

Address _____ Phone _(_____)_____

_____ Mobile _(_____)_____

Social Security # _____

Email _____ Marital Status _____

Spouse name/employer _____

Emergency Contact *(name, address, phone, relationship to you)* _____

_____

Referred by _____

EMPLOYMENT

Employer _____ Occupation _____

Address _____ Work Phone _____

_____

PAYMENT

Who is responsible for your bill? ___Self ___Spouse ___Employer ___Insurance ___Other_____

ALL PAYMENT IS DUE AT TIME OF SERVICE

How will payments be made? ___Cash ___Workers' Comp ___Insurance ___Credit ___No Fault (Auto)

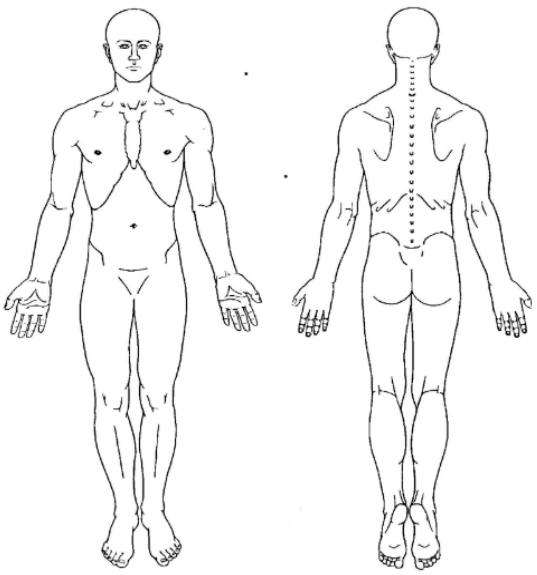
Insurance Company _____ Policy#_____Group#_____

No Fault only: Insurance company _____ Claim #_____

Adjuster name and Contact # _____

PRIMARY COMPLAINT

Mark an "X" on the diagram where there is pain. *Describe the pain, frequency, and activity that brings or makes the pain worse. Examples: dull, sharp, constant, on & off, standing, sitting, walking, laying down, getting up, etc.*



Please describe what is bothering you the most:

_____

_____

_____

_____

_____

_____

Any recent accidents or falls (stairs, ice, etc.)? ___ Yes ___ No

Describe _____

Is your pain a result of a work or car accident? ___ Yes ___ No

Have you ever been in a car accident? ___ Yes ___ No

( ) past year ( ) past 5 years ( ) over 5 years ( ) never

How/when did this pain develop? What caused it? How did it start?

_____

_____

_____

NEW PATIENT INTAKE ***All questions must be answered completely***

Have you ever experienced this problem or similar problem before? When? What started it? When did it start again?

_____

_____

What makes your condition worse? _____

What gives you relief? _____

Have you missed work because of this condition? _____

Has this condition impacted your life?

At home	___ Yes	___ No	How? _____
At work	___ Yes	___ No	How? _____
At recreation	___ Yes	___ No	How? _____
Rest and Sleep	___ Yes	___ No	How? _____

Have you ever received ANY treatment for this condition? ___ Yes ___ No When? _____

Where? _____

Results? _____

List any xrays, CT scan, MRI, labs related to this condition and DATES completed _____

_____

List any chiropractors that have treated you in the past, when you were treated, and what issues they treated

_____

_____

HEALTH HISTORY

Primary Care Doctor _____ Drug Allergies _____

Address _____ _____

_____

Phone _____

Do you have a history of any of the following:				List all surgeries and dates
Cancer (of any kind)	___ Yes	___ No	When? _____	_____
Heart Attack	___ Yes	___ No	When? _____	_____
Stroke	___ Yes	___ No	When? _____	_____
Diabetes	___ Yes	___ No	When? _____	_____
Pregnancy	___ Yes	___ No	When? _____	Currently taking a blood thinner? ___ Yes ___ No

List any other health conditions you are being treated for: _____

_____

Current medications: _____

_____

AUTHORIZED SIGNATURE(S)

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts the assignment below. I authorize payment of medical benefits to Loft Chiropractic for all medical services provided.

_____ _____

Patient, insured and/or authorized representative signature Date