



New Patient Intake

Name: _____ Date: _____

Mailing Address: _____

City _____ State _____ Zip _____

Email address: _____

Phone # (C) _____ (W) _____ Cell Phone Provider _____

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact: _____ Relation: _____

Phone #: (H) _____ (W) _____ (C) _____

May we collaborate and share your progress with your PCP? Yes No

Primary Care Physician Name: _____ Phone #: _____

How did you hear about our practice? _____

What is your chief complaint today? _____

Please list any additional health complaints _____

Please list any surgeries (with dates) and/or medical conditions (past & present) _____

Family History: Please specify members of your family including extended family who have these illnesses.

Cancer: _____ Hypothyroidism: _____

Heart Disease: _____ High Blood Pressure: _____

Hypoglycemia: _____ Obesity: _____

Current Medications/Supplements		
Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time. Are You Pregnant? Yes No

Signature: _____ Date: _____

Review of Systems

Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Please mark if you have experienced any of these symptoms within the **last month**:

Neurological	<input type="checkbox"/> Migraines	Skin	<input type="checkbox"/> Eczema
	<input type="checkbox"/> Headaches		<input type="checkbox"/> Dermatitis
	<input type="checkbox"/> Slurring of speech		<input type="checkbox"/> Excessive sweating
	<input type="checkbox"/> Ringing in ear		<input type="checkbox"/> Rashes
	<input type="checkbox"/> Dizziness		<input type="checkbox"/> Brittle nails
	<input type="checkbox"/> Pins/Needles Arms		<input type="checkbox"/> Hair loss
	<input type="checkbox"/> Pins/Needles Legs		<input type="checkbox"/> Increased bleeding
	<input type="checkbox"/> Cold Feet		<input type="checkbox"/> Easy bruising
	<input type="checkbox"/> Fainting		<input type="checkbox"/> Numbness/tingling
	<input type="checkbox"/> Fever		<input type="checkbox"/> Cold sweats
Ear/Nose/Throat	<input type="checkbox"/> Altered taste/smell	Genitourinary	<input type="checkbox"/> Uterine fibroids
	<input type="checkbox"/> Night Blindness		<input type="checkbox"/> Ovarian cysts
	<input type="checkbox"/> Sore Throat		<input type="checkbox"/> Cancer (breast, ovarian, prostate,uterine)
	<input type="checkbox"/> Gingivitis		<input type="checkbox"/> Prostate problems
	<input type="checkbox"/> Nose bleeds	Emotional/Mental	<input type="checkbox"/> Depression
	<input type="checkbox"/> Blurred Vision		<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Light bothers eyes		<input type="checkbox"/> Mood swings
Cardiovascular	<input type="checkbox"/> Chest pain		<input type="checkbox"/> Irritability
	<input type="checkbox"/> Palpitations- racing heart beat		<input type="checkbox"/> Memory loss
	<input type="checkbox"/> Swelling in hands/feet		<input type="checkbox"/> Confusion
	<input type="checkbox"/> Anemia		<input type="checkbox"/> Nervousness
Respiratory	<input type="checkbox"/> Recurrent respiratory infections	Energy	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Asthma		<input type="checkbox"/> Hyperactivity
	<input type="checkbox"/> Chest congestion		<input type="checkbox"/> Restlessness
	<input type="checkbox"/> Wheezing		<input type="checkbox"/> Insomnia
	<input type="checkbox"/> Frequent sneezing		<input type="checkbox"/> Decreased libido
	<input type="checkbox"/> Shortness of breath		<input type="checkbox"/> Stress
			<input type="checkbox"/> Tension
Gastrointestinal	<input type="checkbox"/> Stomach pains or cramping	Weight	<input type="checkbox"/> Decreased appetite
	<input type="checkbox"/> Constipation		<input type="checkbox"/> Weight gain
	<input type="checkbox"/> Reflux or heartburn		<input type="checkbox"/> Inability to lose weight
	<input type="checkbox"/> Bloating		<input type="checkbox"/> Food cravings
	<input type="checkbox"/> Gas		<input type="checkbox"/> Binge eating
	<input type="checkbox"/> Nausea or vomiting		<input type="checkbox"/> Water retention
	<input type="checkbox"/> Bowel/ bladder changes		<input type="checkbox"/> Sudden weight loss
Musculoskeletal	<input type="checkbox"/> Joint pain	Allergies	<input type="checkbox"/> Hives
	<input type="checkbox"/> Arthritis		<input type="checkbox"/> Runny nose
	<input type="checkbox"/> Chronic pain		<input type="checkbox"/> Itchy/Watery eyes
	<input type="checkbox"/> Muscle aches		<input type="checkbox"/> Congestion
	<input type="checkbox"/> Neck pain		
	<input type="checkbox"/> Back pain		
	<input type="checkbox"/> Arm pain		
	<input type="checkbox"/> Knee/leg pain		<input type="checkbox"/> None of the above
	<input type="checkbox"/> Night pain		
	<input type="checkbox"/> Jaw problems		

Functional Rating Index

In order to assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one which most closely describes your condition *right now*.

Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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Personal Care (washing, dressing, etc.)

No pain with no restrictions	Mild pain with no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
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Travel (Driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
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Work

Can do usual work plus unlimited extra work	Can do usual work with no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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Frequency of pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
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Lifting

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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Walking

No pain with any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
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Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing
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HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Authorization and Assignment

Please initial next to each line that *applies to you*

- AUTHORIZATION TO RELEASE INFORMATION (if applicable):** You are authorized to release any information you deem appropriate concerning my physical condition to my insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.
- ASSIGNMENT OF PAYMENT (if applicable):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.
- MEDICARE ASSIGNMENT (if applicable):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.
- ACKNOWLEDGEMENT AND UNDERSTANDING:** I hereby acknowledge;
- A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
- B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems P.C., will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

Patient Signature _____

Date _____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Hawkeye Chiropractic LLC. I understand and am informed that, while extremely rare, there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature _____

Date _____

Parent/Legal guardian name (please print) _____

Guardian Signature _____

Date _____