

PATIENT INFORMATION

PATIENT NAME

Last Name _____ First Name _____ Middle _____
Gender: M F Date of Birth ____ / ____ / ____ Age _____ SS# _____
Home Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____
Employer Name _____ Occupation _____
Employer Address _____ Apt# _____
City _____ State _____ Zip _____

SPOUSE OR GUARDIAN

Last Name _____ First Name _____ Middle _____
Employer Name _____ Work Phone# _____
Date of Birth ____ / ____ / ____ SS# _____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ Middle _____
Home Phone # _____ Work Phone# _____
Relation to Patient _____

PAYMENT METHOD For all services that are not paid by a third party.

Cash Check Visa Mastercard Discover American Express

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____
Signature of patient or person acting on patient's behalf Date

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____
Signature of patient or person acting on patient's behalf Date

INSURANCE INFORMATION

Patient Last Name	First Name	Middle
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INSURANCE TYPE Check all those that apply

SELF INSURANCE (CONSUMER DIRECTED) <input type="checkbox"/> Personal Health Insurance (not sponsored by employer) <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Medicare Savings Account (MSA) <input type="checkbox"/> Other _____	EMPLOYER SPONSORED (PRIVATE SECTORS) <input type="checkbox"/> Group Health Insurance <input type="checkbox"/> Self-Funded Benefit Plan <input type="checkbox"/> Private Schools <input type="checkbox"/> Health Reimbursement Arrangement (HRA)	GOVERNMENTS (PUBLIC SECTORS) <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part C <input type="checkbox"/> Medicaid <input type="checkbox"/> Municipal (city, state, etc.) <input type="checkbox"/> Other _____	OTHER TYPES <input type="checkbox"/> Personal Injury (Auto, etc.) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Church <input type="checkbox"/> Other _____
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INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____	Phone # () _____
Insured's Name _____	ID/Policy # _____
Insurance Company _____	Phone # () _____
Insured's Name _____	ID/Policy # _____
Insurance Company _____	Phone # () _____
Insured's Name _____	ID/Policy # _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____

Relationship to Patient _____ SS# _____

Home Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone# _____

Employer Name _____ Occupation _____

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____

Signature of patient or person acting on patient's behalf
Date

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x _____

Signature of patient or person acting on patient's behalf
Date

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ Date: _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ male female

Address: _____

Marital status

S	M	W	D	SEP
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Phone #: home: _____ work: _____

E-mail address: _____

Occupation: _____ Employer: _____

Mark (c) for current problems, check and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
 - Bladder infection
 - Blood in urine
 - Kidney infection
 - Kidney stones
 - Prostate trouble
 - Pus in urine
 - Stress incontinence
- Urination
- Overnight more than twice
 - More than 8x in 24hrs
 - Decreased flow/force
 - Painful urination
 - Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

Menstrual flow

- Reg. Irreg. Pain / cramps
- Days of flow: ____ Length of cycle: ____
- Date - 1st day last period: _____
- Are you pregnant? yes, no
- If yes, how many months? ____
- How many children do you have? ____
- Birth control method: _____
- Date of last PAP test: _____
- normal, abnormal
- Date of last mamogram: _____
- normal, abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

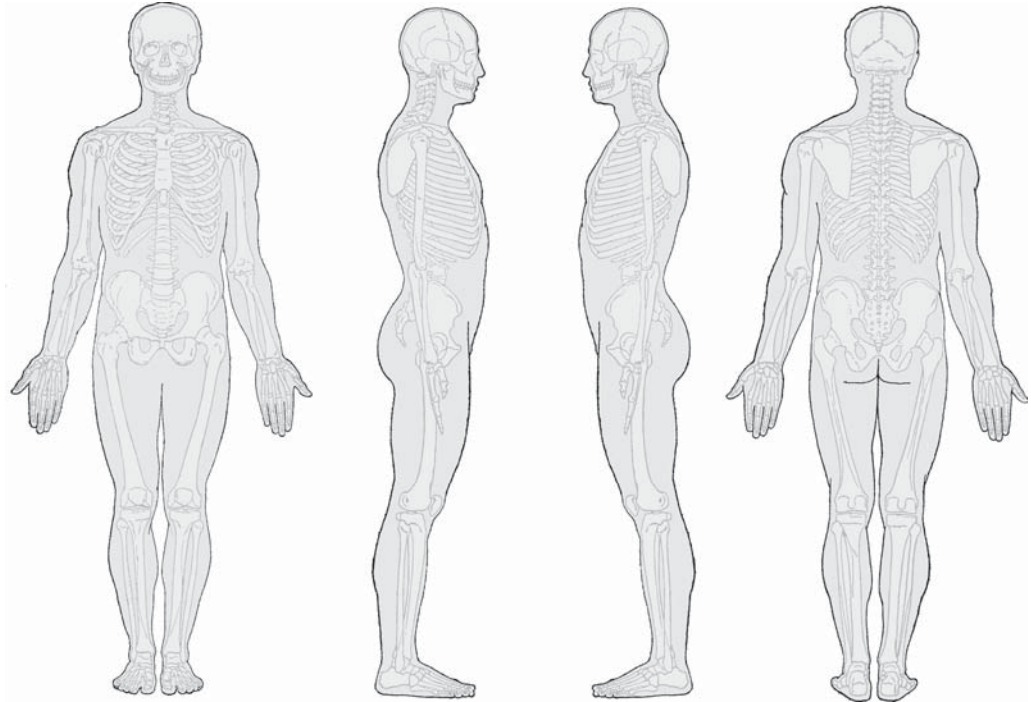
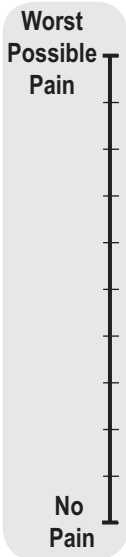
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

Please mark your area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits

	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____