SHILOH CHIROPRACTIC

New Patient Intake and History Form – Paper Version

DEMOGRAPHICS

First Name _________________________ MI ___ Last Name __________________________

Called Name _____________________________ □ Male □ Female Age___________

Date of Birth _____ / _____ / _____ Females: Date of Last Period _____/_____/_____

Mobile Phone (_____) _____-______ Home (_____) _____-______ Work (_____) _____-______

Email ____

Note: We do not spam or trade/sell your information. Without a mobile phone, we cannot send text appointment reminders. Without email, we cannot send email appointment reminders, coupons and/or specials.

Marital Status: □ Single □ Married □ Widowed □ Divorced

Spouse's Name _________________________________

Street Address ____

City State and Zip ____

SSN _______-______-_______ Work Status □ Employed □ Unemployed □ Student

Employer ________________________ City, State and Zip _____________________________

How did you hear about us? ____

Have you been to a chiropractor before? □Yes □No

If yes, who was the doctor? Dr. ____________________ Last treatment ________________

MEDICAL HISTORY

Check all conditions that you have or have had:

□ Broken/Fractured Bone
□ High Blood Pressure
□ Arthritis (Osteoarthritis)
□ Epilepsy
□ Ruptures
□ Coughing Blood
□ Alcoholism
□ Suicidal Thoughts (current)
□ Circulatory Problem
□ Low Blood Pressure
□ Rheumatoid Arthritis
□ Congenital Disease
□ Hernias
□ Ulcers
□ Drug Addiction
□ Gall Bladder Issues
□ Excessive Bleeding
□ Strokes
□ Seizures / Convulsions
□ Pace Maker
□ Cancer
□ Eating Disorder
□ Depression
□ HIV / AIDS
□ None □ Others ____

MEDICAL HISTORY CONTINUED

Use the space below to list any major illnesses, injuries and hospitalizations

___

___

___

Use the space below to list medications & supplements (use the back of this form if necessary)

___

Primary Doctor's Name ______________________________ Phone ______________________

City/State ____

Pregnancies ____

Do you use tobacco? □ No □ Yes (type/quantity ___________________________________)

Do you consume alcohol? □ No □Yes (Quantity/mo_________________________________)

Caffeine Use ____

FAMILY HISTORY

Do you have children? □ No □Yes

Use the space below to provide names, ages and conditions/illnesses (if any):

___

___

___

Does anyone suffer from the following? (And if so, whom)

□ Arthritis □ Neck Pain □ Back Pain □ Headaches
□ Migraines □ Pinched Nerves □ Disc Problems □ Neuritis
□ Scoliosis Who:____

Are you adopted? □ No □ Yes

If you have information about your biological family, please answer the following:

FAMILY HISTORY CONTINUED

-Paternal History- Is your father alive? □ Yes □ No

If yes, how old is he? _______ If no, age of death and cause of death ________________

Are there any major diseases on your father's side of the family? ________________________

____

-Maternal History- Is your mother alive? □ Yes □ No

If yes, how old is she? _______ If no, age of death and cause of death ________________

Are there any major diseases on your mother's side of the family? ________________________

____

HISTORY OF CHIEF COMPLAINT

What seems to be troubling you? We'll discuss this more in the consultation

____

____

____

BILLING INFORMATION

To whom should we bill your care? □ Self □ Health Insurance □ Workers Comp □ Auto Injury

Do you have a Health Savings Account? □ Yes □ No

Insurance Company Name ____

Phone Number (Provider Line) ____

Member Name ____

Member Number _______________________________ Group __________________________

Member Date of Birth _____/_____/_____ Relationship to you ________________________

Attorney (if workers comp or auto injury) ____

Attorney phone (_____) _____-________ City/State __________________________________

AGREEMENT

The information I have provided is authentic and true to the best of my knowledge. I authorize payment of insurance benefits directly to Shiloh Chiropractic LLC. I authorized the doctor to release all information necessary to communicate with personal physicians and other healthcare providers, services and payers and to secure the payment of benefits. I understand that I am ultimately responsible for all costs of care incurred at Shiloh Chiropractic LLC as determined by my treating doctor; any fees for professional services will be immediately due and payable. I agree to pay a $50 “no call no show fee” if I do not keep my appointment or cancel with a 24 hour notice prior to the appointment time. I understand and agree to allow Shiloh Chiropractic to use information in this form for the purpose of the diagnosis, treatment, payment, healthcare operations and coordination of care. Shiloh Chiropractic has made me aware that this patient health information will be used in Shiloh Chiropractic and my rights concerning the privacy of said information is safeguarded. I understand that Shiloh Chiropractic has a published HIPAA policy at its office and that I may request to view that in its entirety at any time upon request during normal working hours.

I, the undersigned, agree to the statements in this agreement section.

Print Name Sign Name Date

Relationship to the patient (if under 18 or unable to sign) _______________________________
IF UNDER 18 YEARS OF AGE, HAVE A PARENT OR A LEGAL GUARDIAN SIGN ABOVE.

STOP! This section is for the doctor. Do not fill this portion out.

MOI ____

ONS ____

PAL ____

PRV ____

QUA ____

RAD ____

SEV @n _____/10 @a _____/10 @w _____/10

TIM ____

C/S Flex ___ Ext___ LLF ___ RLF ___ LLR ___ RLR ___

L/S Flex___ Ext___ LLF___ RLF___