

## Shiloh Chiropractic PATIENT INTAKE FORM

Date: \_\_\_\_\_

### PATIENT INFORMATION

First Name		Middle Name		Last Name		Called Name "Nickname"	
Gender M   F	Birth Date / /	Marital Status S   M   D   W		Your Address (Street)			
City		State	Zip	Driver's License Number		Social Security Number - -	
Work/Student Status	Employer	Occupation		Primary Medical Doctor Name & Office Location (or Address)			
Home Phone ( ) -		Cell Phone ( ) -		Cell Provider (IE: AT&T)	Work Phone ( ) -		
Email Address <i>Your email is not spammed nor is it sold or given to any third party</i>						<i>We send texts and emails to update you with appointment times and invoices. Please notify us if you do not wish to receive said updates.</i>	
Which method of contact do you prefer?	How, or by whom, did you hear about us?		Have you ever been to a chiropractor? (Who/When)		Date of Last Period (females Only) / /		

### INSURANCE INFORMATION *(Fill out only if applicable)*

(For Primary Insurance) Member's Name	Member's Social - -	Member's Date of Birth / /	Your relationship to member:
(For Secondary Insurance) Member's Name	Member's Social - -	Member's Date of Birth / /	Your relationship to member:

### PAST MEDICAL HISTORY *(Please indicate each line with a "Y" for yes or "N" for no.)*

Have you ever been diagnosed as having or have suffered from:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Broken / Fractured Bones  | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder       |
| <input type="checkbox"/> Circulatory Problems      | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Alcoholism            |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Pace Maker     | <input type="checkbox"/> Drug Addiction        |
| <input type="checkbox"/> Seizures / Convulsions    | <input type="checkbox"/> Strokes        | <input type="checkbox"/> HIV Positive          |
| <input type="checkbox"/> A Congenital Disease      | <input type="checkbox"/> Ruptures       | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers                |

Others: \_\_\_\_\_

Do you have a history of stroke or hypertension? (Explain) \_\_\_\_\_

Have you had any major illness, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Please list any other health problems / hospitalizations you have had, no matter how insignificant they may seem: \_\_\_\_\_

### CURRENT CHIEF COMPLAINT HISTORY *(What brings you into the office)*

What brings you into the office? \_\_\_\_\_

Is this due to an auto accident? \_\_\_\_\_ Work Accident? \_\_\_\_\_

Have you ever had similar issues? \_\_\_\_\_ Explain: \_\_\_\_\_

(Women only) Are you pregnant? \_\_\_\_\_

Days lost from work: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

**SOCIAL HISTORY**

Do you drink alcohol? \_\_\_\_ If yes, how many "Beer Equivalents" per week \_\_\_\_  
 Do you use tobacco? \_\_\_\_ Do you smoke? \_\_\_\_ If yes, packs per day \_\_\_\_  
 How many "coffee / soda can equivalents" per day? \_\_\_\_ cups  
 Which vitamins, herbs, and supplements do you take? \_\_\_\_\_  
 Medications? \_\_\_\_\_

Do you exercise? \_\_\_\_ Describe: \_\_\_\_\_  
 What are your hobbies? \_\_\_\_\_  
 What percentage of time during the day (at home or at your job away from home) do you spend:  
 Lifting: \_\_\_\_ Sitting: \_\_\_\_ Bending: \_\_\_\_ Computer: \_\_\_\_

**FAMILY HISTORY**

Are you adopted? \_\_\_\_ If yes, can you fill out the following concerning your *natural* parents? \_\_\_\_  
 Is your father alive? \_\_\_\_ If yes, how old? \_\_\_\_ If no, how old when deceased? \_\_\_\_  
 If deceased, cause of death: \_\_\_\_\_  
 Is your mother alive? \_\_\_\_ If yes, how old? \_\_\_\_ If no, how old when deceased? \_\_\_\_  
 If deceased, cause of death: \_\_\_\_\_  
 Is there any disease or illness in your family? (parents, siblings, children, aunts, uncles, grandparents): \_\_\_\_  
 If so, list what they are and who suffered(s) from them: \_\_\_\_\_

In particular, does anyone have: (If yes, write "F" for father, "M" mother, "S" Sister, "B" Brother.)

- |                   |                     |                     |
|-------------------|---------------------|---------------------|
| ____ Tuberculosis | ____ Cancer         | ____ Mental Illness |
| ____ Diabetes     | ____ Asthma         | ____ Heart Disease  |
| ____ Stroke       | ____ Kidney Disease | ____ Lung Disease   |
| ____ Arthritis    | ____ Liver Disease  | ____ Other _____    |

**INSURANCE AND AGREEMENT**

Please check any and all insurance coverage that might be applicable to this case. Ensure the information regarding insurance is filled in correctly above.

\_\_\_\_ Major Medical      \_\_\_\_ Workers' Compensation      \_\_\_\_ Medicare  
 \_\_\_\_ Auto Accident      \_\_\_\_ Medical Savings and Flex Plans      \_\_\_\_ Other: \_\_\_\_\_

*I authorize payment of insurance benefits directly to Shiloh Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care incurred at Shiloh Chiropractic as determined by my treating doctor; any fees for professional services will be immediately due and payable. I understand and agree to allow Shiloh Chiropractic to use information in this form for the purpose of diagnosis, treatment, payment, healthcare operations and coordination of care. Shiloh Chiropractic has made me aware that this patient health information is going to be used in Shiloh Chiropractic and my rights concerning the privacy of said information is safeguarded. I have read and accept HIPAA NOTICE.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_