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 _____/_____/_____

Street Address _____

City State and Zip _____

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.

SSN _____-_____-_____ Work Status □ Employed □ Unemployed □ Student

Marital Status: □ Single □ Married □ Widowed □ Divorced

Spouse's Name _____

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	□ Circulatory Problem	□ Excessive Bleeding
□ High Blood Pressure	□ Low Blood Pressure	□ Strokes
□ Arthritis (Osteoarthritis)	□ Rheumatoid Arthritis	□ Seizures / Convulsions
□ Epilepsy	□ Congenital Disease	□ Pace Maker
□ Ruptures	□ Hernias	□ Cancer
□ Coughing Blood	□ Ulcers	□ Eating Disorder
□ Alcoholism	□ Drug Addiction	□ Depression
□ Suicidal Thoughts (current)	□ Gall Bladder Issues	□ 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? □ Yes □ No (type/quantity _____)

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

Caffeine Use _____

FAMILY HISTORY

Do you have children? □ Yes □No

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? □ Yes □ No

If you have information about your <u>biological family</u>, 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___