Regional Chiropractic Center

New Patient Intake Form

Patient Information:

Name: _____

Parents name (If Minor): _____

Male / Female **D.O.B:** _____ **Age:** _____

Social Security #: _____

Address: _____

Phone number: _____

Email: _____

Emergency Contact:

Name: _____ **Phone Number:** _____

Patient Condition

1. What is your major symptom / problem?

_____

2. When did these symptoms begin? _____

3. What happened to cause the pain?

_____

4. Is your condition getting progressively worse? YES / NO

5. Is this problem: CONSTANT / COMES AND GOES

6. How does it feel? (circle below):

Burning Sharp Shooting Dull Aching Stiff Tingling

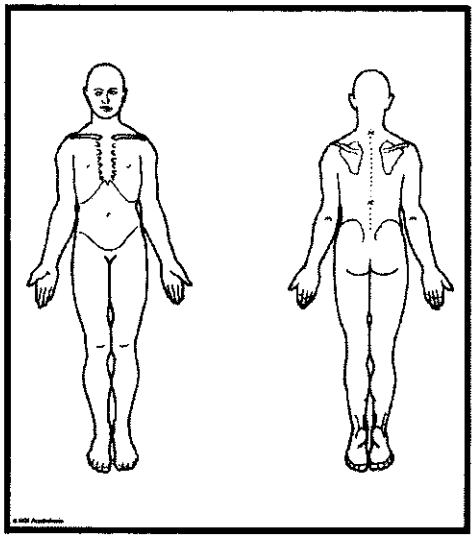
Other: _____

7. Movements/Activities that worsen the pain: (Circle below)

Bending Lying Down Driving Sitting Standing Walking

Other: _____

Circle Area(s) of pain:



8. Does anything help improve the pain?

_____

_____

9. Does it interfere with: (Circle below)

Work Sleep Daily Routine Recreation

Other: _____

10. Family History of back or neck pain? YES / NO

- **Parents Sibling Grandparents**
- **Other:** _____

11. Any previous treatments done for this condition? (Circle below)

Chiropractic Orthopedic Neurologist Physical Therapy Surgery

Other: _____

12. Are you pregnant? YES / NO How far along? _____

13. Any other health conditions or illnesses? (List below)

_____

_____

14. Any surgeries? Please note when and what was done:

_____

15. Any automobile Accidents? YES / NO Date: _____

16. Broken bones? Please note when and what bone(s) were broken:

_____

17. Any major falls or head injuries?

Please note when and what type of injury occurred:

_____

18. Please List Current Medications Below: If easier, have the medication list copied at the front desk.

1. 6.
2. 7.
3. 8.

FEES ARE PAYABLE AT TIME OF SERVICE!

I hereby authorize Dr. Ladd or Dr. Bell and whomever designated as the assistant to administer treatment deemed necessary. I understand that Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: To locate, analyze, and correct spinal interference to the nervous system. I verify all information provided is accurate and true.

I the undersigned,
*have insurance with (name of insurance)*_____
and assign directly to Regional Chiropractic Center, INC. (Dr. Wayne Ladd or Dr. Christopher Bell) all benefits.

I hereby authorize the office to release all information necessary to secure payment of benefits. I authorize and use this signature on all insurance submissions whether manual or electronic.

I acknowledge that a copy of the financial policies has been offered to me and payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of minors/children.

I accept full responsibility for ALL charges NOT covered by insurance. I understand that I am financially responsible for all charges, regardless of insurance payment.

I acknowledge that a copy of HIPAA privacy practices have been offered to me.

I hereby authorize Regional Chiropractic Center to furnish information to any referring institute/physician or insurance concerning my illness and treatment.

I have read the explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Signature:

_____ **Date:** _____

Parent/Guardian Signature:

_____ **Date:** _____