Gateway Chiropractic Bay Colony, PLLC

NEW PATIENT INTAKE FORM

(PLEASE PRINT CLEARLY)

Today's date:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:	City:	State:	Zip Code:	Nickname:
Home ph: ( )	Work ph.: ( )	Cell ph.: ( )	Sex: ❑ M ❑ F	
Email:	Social Security Number:	Birth date (mm/dd/yyyy): / /		
Driver's Lic #:	Religion:	Race:		
Occupation:	Employer:	Employer phone: ( )		
Spouse's name:	Do you have children? ❑ Yes ❑ No	How many?	Ages: _____ _____ _____ _____ _____	
Referred to clinic by:	Other family members seen here:			

REASON FOR VISIT

(Please give your insurance card and picture ID to the receptionist.)

The reason for this visit:

Please describe pain and its location:

When did condition begin? / /

Is this condition getting worse? ❑ Yes ❑ No

The pain/discomfort… ❑ is constant ❑ comes & goes

What makes your condition worse? (check all that apply)

❑ Sitting ❑ Lifting
❑ Standing ❑ Transitioning
❑ Bending ❑ Other ________________

What has provided relief? (check all that apply)

❑ Nothing ❑ Medication
❑ Rest ❑ Exercise
❑ Ice ❑ Activity
❑ Heat ❑ Other ________________

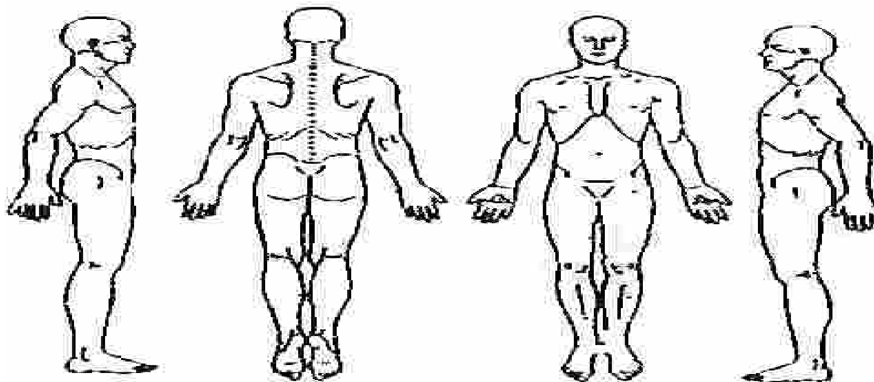
Quality of pain is: ❑ Dull ❑ Sharp ❑ Burning ❑ Numbness ❑ Tingling ❑ Other __________________

Would you describe the pain as radiating/shooting? ❑ Yes ❑ No
If so, where? ____________________________________

When is the pain worse? ❑ Morning ❑ Afternoon ❑ Evening ❑ Other ______________________

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No
If so, who, when & where? _________________________________ _____________ Phone# _____________________

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No
If so, who, when & where? ____ Phone# _____________________



Please Mark Area(s) of pain

XX Burning,
/// Numbness/Tingling
== Tightness
OO Dull/Achy

Please indicate the intensity of your pain/discomfort today, 10 being worst

0	1	2	3	4	5	6	7	8	9	10

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INSURANCE INFORMATION				
Company Name:	Address:	City:	St:	Zip:
Phone:	Insured:	Policy#:	Group#:	

IN CASE OF EMERGENCY		
Who should we contact:		Relation:
Home phone #: ( )	Cell phone #: ( )	Work phone #: ( )
Who is your medical doctor? When was your last visit to this doctor?		Phone #: ( )

HEALTH HISTORY		
List previous surgeries/treatments with dates:		
Current Medication(s):		
Allergies:		
Family Health History: Father ❑ Living ❑ Deceased	❑ Good Health ❑ Health Condition(s):	
Mother ❑ Living ❑ Deceased	❑ Good Health ❑ Health Condition(s):	
Sibling: relation ____________ ❑ Living ❑ Deceased	❑ Good Health ❑ Health Condition(s):	
Sibling: relation ____________ ❑ Living ❑ Deceased	❑ Good Health ❑ Health Condition(s):	
List any past serious accidents with dates:		
Do you: Take supplements or vitamins? □ Yes □ No	Exercise? □ Yes □ No	Are you on a special diet? □ Yes □ No Since / /
Do you smoke? □ Yes, how long? _______ □ No	How much? ______ packs/day	History of drug/alcohol abuse? □ Yes □ No
Do you wear orthotics? □ Yes □ No	Age of mattress? _______ yrs	Are you pregnant? □ Yes How long?___ □ No Nursing? □ Yes □ No

CURRENT/PAST MEDICAL CONDITIONS

Circle "C" if the problem is a current condition and "P" if you have had the condition in the past

General	Muscle & Joint	Eyes, Ears, Nose & Throat	Gastrointestinal
C P Fainting/seizures/epilepsy	C P Lower back problems	C P Sinus problems	C P Constipation/diarrhea
C P Psychiatric problems	C P Arthritis/bursitis/tendonitis	C P Visual problems	C P Nausea/vomiting
C P Cancer	C P Shoulder/Elbow/Wrist/Hand Pain	C P Glaucoma	C P Sudden weight loss
C P Fatigue	C P Artificial bones/joints	C P Hearing problems	C P Ulcers/colitis
C P Bruise easily	C P Frequent neck pain		
C P Anemia	C P Severe/frequent headaches	**Respiratory**	**Cardiovascular**
C P Rheumatic Fever	C P Hip/Knee/Ankle/Foot Pain	C P Emphysema	C P Heart surgery/pacemaker
C P Venereal disease		C P Difficulty breathing	C P Mitral Valve Prolapse
C P Shingles	**Females (only)**	C P Asthma	C P Heart murmur
C P Lightheadedness/dizziness	C P Cramps/backache w/ cycle		C P Artificial valves
C P HIV/AIDS	C P Excessive menstrual flow	**Genito-Urinary**	C P High/Low blood pressure
C P Chemotherapy	C P Irregular cycle	C P Kidney problems	C P Heart attack/stroke
C P Thyroid problems		C P Frequent/painful urination	C P Congenital heart defect
		C P Prostate trouble	

Please list any other medical condition(s) you have ever had:

CONSENT

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

*Patient/Guardian signature*_________________________________ *Date* ___________________