ITHACA FAMILY CHIROPRACTIC

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NEW PRACTICE MEMBER INTAKE FORM

DEMOGRAPHIC INFO **BBAR # :_____**

Today's Date: _____Whom may we thank for referring you to our office?_____

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____City: _____ State: _____ Zip: _____

E-mail Address: _____Mobile Phone: _____Home Phone:_____

Driver's License or Photo ID: _____Please Provide Copy _____ Work/Other Phone: _____

Do you have Insurance: ❑Yes ❑No ❑Other Name of Primary Ins Co:_____ Secondary Ins Co:_____
If Yes, _____**Please Provide Copy of Card(s) So Our Staff Can Look Into Any Benefits You May Have Before You Start Care**_____

Marital Status: ❑ Single ❑ Married/Engaged/Significant Other ❑Divorced ❑Separated ❑Widowed ❑Other _____

Employer: _____ Occupation: _____

Spouse's Name _____Occupation: _____

Name of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

Interests and Hobbies: _____

HISTORY of COMPLAINT

Please identify any condition(s) that brought you to our office: Primary: _____

Secondary: _____Other: _____Here For Wellness Care Y/N
On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**
Primary or chief complaint : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Timing: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ infrequent

When did the problem begin? _____ When is the problem at its worst? ☐ AM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

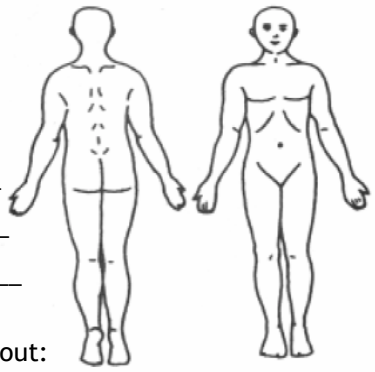
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Second complaint : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Timing: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ infrequent
When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ mid-day ☐ late PM
Other complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Timing: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ infrequent
When did the problem begin? _____ When is the problem at its worst? ☐ AM ☐ mid-day ☐ late PM

Which Activities are limited as a result of your conditions ? Please ✓ check or write
❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Sleeping ❑ Driving ❑ Doing Chores ❑ Doing Computer Work
❑ Recreation ❑ Dressing ❑ Carrying ❑ Lifting ❑ Working ❑ Other: _____

***PLEASE MARK** on the Diagram any symptoms you experience. Use the corresponding **letters that** describe your symptoms: **R = R**adiating
B = Burning **D = D**ull/Stiff **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing
T= Tingling **P** = General Pain **M** = Muscle Tightness **O** = Other



What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY of a WORK or MOTOR VEHICLE ACCIDENT? ☐ No ☐ Yes Date_____

Identify any other recent injury(s) or issues, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Primary Care Physician: _____ Date of Last Exam: _____ Date of last x-ray: _____

Are you currently pregnant?: ☐ Yes ☐ No ☐ Unsure The first day of your last menstrual cycle: _____/_____/_____

Please identify any and all types of hobbies or jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Please list any Drugs, Over The Counter Drugs, Medications, Supplements, Herbs or Other that you are currently taking:

_____

_____

_____

PLEASE identify ALL PAST and any **CURRENT** conditions: please indicate with a **P** for any ***Past conditions*, C** for ***Current*** have**:**

___AIDS/HIV	___ARTHRITIS	___ALLERGIES	___ASTHMA
___ACCIDENT/FALL	___AUTO ACCIDENT	___BACK CURVATURE	___BED WETTING
___CANCER	___CHEST PAIN	___COLON TROUBLE	___CONVULSIONS/EPILEPSY
___DEPRESSION	___DIABETES	___DIGESTIVE ISSUES	___DIARRHEA/CONSTIPATION
___DIZZINESS	___EAR INFECTION	___FAINTING	___FOOT TROUBLE
___FRACTURES	___FLU/COLD OFTEN	___GOUT	___HEADACHES/MIGRAINES
___HEARING LOSS	___HEARTBURN	___HEART PROBLEMS	___HIGH/LOW BLOOD PRESSURE
___HIP PAIN	___HERNIATED DISK	___HIGH CHOLESTEROL	___IMPOTENCE
___JAW PAIN/TMJ	___KIDNEY TROUBLE	___LOSS OF BALANCE	___LOW BACK PAIN/STIFFNESS
___MENOPAUSAL PROBLEMS		___MENSTRUAL PROBLEMS/PMS	___MID BACKPAIN/STIFFNESS
___MULTIPLE SCLEROSIS		___OSTEOPENIA/OSTEOPEROSIS	___UPPER BACKPAIN/STIFFNESS
___PAIN/STIFF NECK		___PAIN W/SNEEZE/COUGH	___PINCHED NERVE
___PNEUMONIA	___PROSTATE ISSUES	___RINGING IN EARS	___SHOULDER PAIN
___SINUS PROBLEMS	___SKIN PROBLEMS	___STROKE	___SWOLLEN/PAINFUL JOINTS
___THYROID ISSUES	___PACEMAKER	___TREMORS	___TROUBLE CONCENTRATING
___TUMORS/GROWTHS	___ULCERS	___TROUBLE SLEEPING	

___DIFFICULTY IN STANDING/WALKING/BENDING/RIDING/TWISTING/LIFTING

___DIFFICULTY BREATHING/UPPER RESPIRATORY PROBLEMS ___NUMBNESS/TINGLING/PAIN IN BUTTOCKS/LEGS/FEET

___NUMBNESS/TINGLING/PAIN IN ARMS/HANDS/FINGERS ___ Other:_____

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY ✓ check or write.

1. Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

2. Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

3. Smoking: ☐ No ☐ Yes – packs/day _____ **Alcohol:** ☐No ☐ Yes – drinks/week_____

4. Caffeine: ☐ No ☐ Yes – cups/day **High Stress:** ☐ No ☐ Yes – reason:

MANY CONDITONS RUN IN FAMILIES PLEASE ✓ CHECK ANY CONDITIONS IN YOUR FAMILY

FAMILY HEALTH HISTORY

Condition	Spouse	Children	Father	Mother	Brothers	Sisters
Shoulder/Arm/Hand Pain						
Arthritis RA/PA/OA						
Asthma						
ADD/ADHD/OCD						
Allergies/ Sinus Issues						
Back Pain Upper/Lower						
Bed Wetting						
Cancer/Tumors						
Carpel Tunnel/Wrist						
Constipation						
Depression						
Diabetes						
Digestive Problems						
Disc Problems						
Ear Infections						
Emphysema or Smoker						
Epilepsy						
Leg/Foot/Heel Pain						
Fibromyalgia/Pain Syndrome						
Headaches/Migraines						
Heart Trouble						
Heartburn/Reflux						
High Cholesterol						
High Blood Pressure						
Hip Pain/Sciatica						
Kidney Trouble						
Menstrual Disorder						
Neck Pain/Jaw Pain/TMJ						
Nervousness/Anxiety						
Pinched Nerve						
Scoliosis						
Smoker						
Sports Activities						
Hypo/Hyper Thyroidism						
Trouble Sleeping						
Other:						

GOALS FOR MY HEALTH:

At Ithaca Family Chiropractic, our goal is to help individuals and families maximize their health. In order for you to reach your best level of health, we work together toward chiropractic, life and health goals. Please ✓ check or write your goals below.

☐ Eat More Healthy Foods	☐ Drink More Water/Less Soda/Less Coffee	☐ Reduce Stress
☐ Exercise More	☐ Time For Me Journal/Write/Meditate More	☐ Lose Weight
☐ Have More Spiritual Time	☐ Live to be 100 in Good Health	☐ Decrease Smoking/Drinking
☐ Improved Posture	☐ Improved Flexibility and Strength	☐ Increased Energy
☐ Enjoy the best possible Life, Pain free	☐ Improved Ability to Focus	☐ Improved Sleep

Other : _____

INSURANCE RELEASE:

I certify that I, and/or my dependent(s) have insurance coverage with _____

I hereby authorize payment to be made directly to Ithaca Family Chiropractic, for any and all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Ithaca Family Chiropractic for any and all services I receive at this office. I authorize the use of my signature on all insurance submissions.

Name of Insured: _____ Relationship to Patient: _____

Birthday of Insured: _____

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to help with my condition at any time throughout the entire clinical course of my care.

_____ _____/_____/_____

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

I authorize Ithaca Family Chiropractic to take any necessary radiographic images for chiropractic care. These images will be provided complimentary for the initial evaluation and are for aiding in specific chiropractic analysis and care only. I understand that in compliance with section 17 & 18 of Public Health Law of 1991, Chapter 165, section 48 & 49, I will be charged a $150 fee for any requested reproduction of these images, time associated and cost of supplies for the copying and transfer of these images outside of the Ithaca Family Chiropractic facility.

please initial that you understand _____

By my signature below I understand and acknowledging the hazardous effects of ionization to an unborn child, and I understand that risks associated with exposure to x-rays are minimal but do exist for adults and children. I will convey any concerns I have with the doctor of chiropractic prior to any x-rays so they can be discussed. After careful consideration I therefore, do hereby consent to have any diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____

Patient or Authorized person's Signature Date

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on _____-_____-_____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.