BERRY HILL CHIROPRACTIC & WELLNESS

New Patient Intake

Today's Date:

ABOUT YOU

Patient Name: ____ Date of Birth: ______________________

What You Prefer To Be Called: _____________________________ □ Male □ Female Age: ____________

Address: ____________________________________ City: ____________ State: _______ Zip: _________

Cell Phone: _______________ Home Phone: _________________ Work Phone: ____________________

Email Address: _________________________________ Marital Status: Single Married Divorced Other

Spouse's Name: ________________________ Do you have any children? □ Yes □ No How Many? _________

Employer: _________________________________ Occupation: _______________________________

Address: _____________________________ City: ______________ State: __________ Zip: ___________

Referred By: ____

INSURANCE INFORMATION

Primary Insurance Co. Name: ____________________________ Phone #: __________________________

Address: ____

Insured's Name: ______________________________ Relation: _______________ DOB: ______________

Insured's ID #: ___________________________ Group or Account #: ______________________________

Insured's Employer: ____

Secondary Insurance Co. Name: __________________________ Phone #: __________________________

Address: ____

Insured's Name: ______________________________ Relation: _______________ DOB: ______________

Insured's ID #: ___________________________ Group or Account #: ______________________________

Insured's Employer: ____

ACCOUNT INFORMATION (Person ultimately responsible for account)

Name: ____ Relation: __________________________

Billing Address: ____

Phone #: ____

_______ (Initial if agree) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

EMERGENCY CONTACT INFORMATION

Who should we contact? _______________________________ Relation: __________________________

Cell Phone: _______________ Home Phone: ___________________ Work Phone: ____________________

Who is your Medical Doctor? ________________________________ Phone #: ______________________

*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

*Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with our office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider 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.

Signature: ____Date: ___________________________

□ Adult □ Parent or Guardian

REASON FOR VISIT

Reason for Today's visit: □ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness

Are you in pain? □ Yes □ No Rate your pain with the following scale: no pain 1 2 3 4 5 6 7 8 9 10 intense pain

Did your injury occur during? □ Work □ Sports/Play □ Auto Accident □ Routine/Household Activity

When did your condition/accident occur? ________________ Where did your injury occur? ____________________

Please explain the injury: ____

____

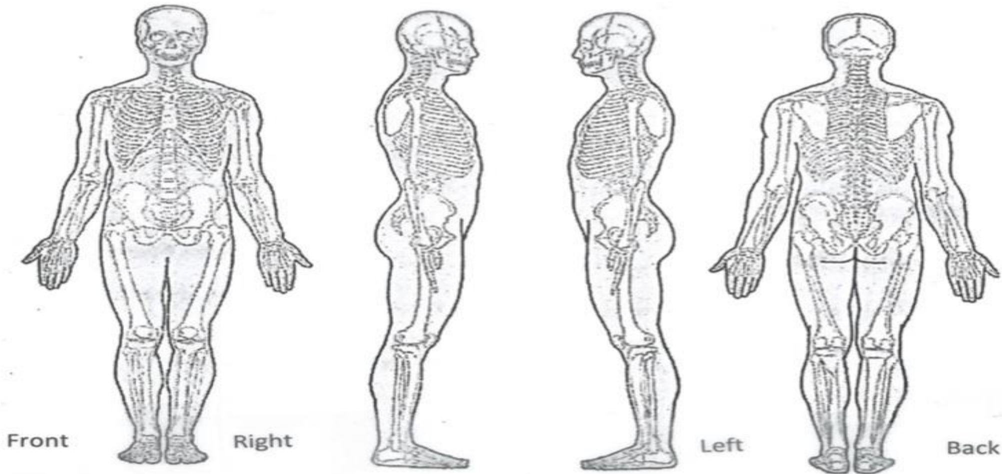
Is your condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is your condition interfering with your: □ Work □ Sleep Daily routine If so, how: __________________________

Has this or something similar happened in the past? □ Yes □ No Explain: __________________________________

____

Using the body chart, please circle all affected areas:



Have you been treated by a Medical Physician for this condition? □ Yes □ No If so, where? ____________________

Have you ever been treated by a Chiropractor? □ Yes □ No Clinic/Dr's name: _______________________________

HEALTH HISTORY

Please list your medications and dosages: ____

____

Do you have or have you had any of the following diseases, medical conditions or procedures? (If you have please check the box)

□ Heart Attack/Stroke	□ Alcohol/Drug Abuse	□ Frequent Neck Pain	□ Glaucoma
□ Artificial Valves	□ Cancer	□ Rheumatic Fever	□ Hepatitis
□ Emphysema/Asthma	□ Psychiatric Problems	□ Sinus Problems	□ Shingles
□ High/Low Blood Pressure	□ Fainting/Seizures/Epilepsy	□ Lower Back Problems	□ Ulcers/Colitis
□ Mitral Valve Prolapse	□ Chemotherapy	□ Congenital Heart Defect	□ HIV/AIDS/ARC
□ Difficulty Breathing	□ Heart Murmur	□ Artificial Joints/Implants	□ Kidney Problems
□ Heart Surgery/Pacemaker	□ Venereal Disease	□ Severe/Frequent Headaches	□ Tuberculosis
□ Arthritis	□ Anemia	□ Diabetes	

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ______________

____

List any past serious accidents with dates: ____

Please list anything that you may be allergic to: ____

Family Health History: ____

Do you take supplements/vitamins? □ Yes □ No Do you exercise? □ Yes □ No ______ hours per week

Do you smoke? □ Yes □ No How much? _________ How long? _________ Are you: □ Right or □ Left handed?

Are you wearing: □ Shoe lifts □ Inner Soles □ Arch Supports Are you dieting: □ Yes □ No Since: ___________

For women: Are you taking Birth Control? □ Yes □ No Are you pregnant? □ Yes □ No How many weeks? ______

Are you nursing? □ Yes □ No When did you have the child? ____