# Patient Intake Form

Patient Name:_____ Date:_____ Email: _____
SS #:_____ DOB:_____ ☐ Male ☐ Female Phone_____
Cell Phone _____Check appropriate Box**:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Address _____City _____
State_____ Zip_____ Occupation:_____ Employer Name:_____
Work phone:_____ Spouse/ Emergency Contact:_____Phone_____

How did you hear about this office? ☐ **Friend/Family (name) _____** ☐ **Facebook** ☐ **Google** ☐ **Internet** ☐ **Advertisement** ☐ **Insurance Co.** ☐ **Website** ☐ **Drove by**

**Payment for services:** ☐ **Cash/CC** ☐ **Medicare/Medicaid** ☐ **Health Ins.** ☐ **Auto Ins.** ☐ **Workers Comp**
Person responsible for this account _____Relationship_____
E-Mail _____Cell Phone _____
**Are you represented by an Attorney?** ☐ **Yes** ☐ **No** **Attorney name: _____Phone:_____**

**Medical insurance Information:** ***Please complete the following and give insurance card to staff:***
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#_____ Name of Employer_____
Work Phone _____Insurance Co._____Group #_____
Ins. Co. Address_____City_____State ____ Zip_____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS**
**AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE**
**AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Patterson Chiropractic Clinic / Progressive Medical Spine and Joint** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 _____. X_____
(Patient signature)

X_____
(Signature of Guardian if applicable)

X_____
(Please print patient name)

## Please describe you present complaints and Rate the severity of your symptoms on a scale of 1-10, with 10 being the most severe.

**1**_____ _____ **4**_____ _____

**2** _____ _____ **5** _____ _____

**3** _____ _____ **6**_____ _____

**History of Present illness:**

**Duration:** _____ **Timing**: _____

(How long have you had this pain/ problem and when did it start?) (Does the pain/problem occur at a specific time?)

**Associated Signs/Symptoms** _____ **Modifying Factors**_____

_____ _____

(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had before?)

**Have you seen any other provider/ doctor for your conditions/injury? ☐ Yes ☐ No**

**If so, who?_____ Were medications prescribed?_____**

**X-rays? List Areas:_____**

**Past Medical History**

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Measles…… NO YES | Anemia……...NO YES | Back Trouble……NO YES | Hepatitis……..NO YES |
| Mumps…… NO YES | Bladder Infection……..NO YES | High Blood Pressure…….NO YES | Ulcer……NO YES |
| Chicken Pox…… NO YES | Epilepsy……NO YES | Low Blood Pressure…….NO YES | Kidney Disease……NO YES |
| Whooping Cough… NO YES | Migraine Headaches…NO YES | Hemorrhoids……NO YES | Thyroid Disease……NO YES |
| Scarlet Fever…… NO YES | Tuberculosis……NO YES | Date of Last Chest X-Ray_____ | Bleeding Tendency……NO YES |
| Diphtheria…… NO YES | Diabetes……NO YES | Asthma……...NO YES | Any Other Disease……..NO YES |
| Small pox…… NO YES | Cancer……NO YES | Hives of Eczema……..NO YES | (Please List): |
| Pneumonia…… NO YES | Polio……NO YES | AIDS & HIV……NO YES | |
| Rheumatic Fever… NO YES | Glaucoma……NO YES | Infectious Mono……NO YES | _____ |
| Arthritis…… NO YES | Hernia……NO YES | Bronchitis……NO YES | |
| Venereal Disease… NO YES | Blood or Plasma Transfusion……..NO YES | Mitral Valve Prolepses….NO YES | _____ |
| | | Stroke……NO YES | |

**Previous Hospitalizations/Surgeries/Serious Illnesses** When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Medication:** (include nonprescription)

_____

_____

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

**Patient Social History:**

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

**Family Medical History:**

| | Age | Disease | If Deceased, Cause Of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

**Eyes/Ears/Nose/Throat/Respiratory**

| | |
|---|---|
| Asthma | 1 2 3 4 5 |
| Stuffy Nose | 1 2 3 4 5 |
| Hay Fever | 1 2 3 4 5 |
| Sore throat | 1 2 3 4 5 |
| Chronic Cough | 1 2 3 4 5 |
| Chest Congestion | 1 2 3 4 5 |
| Frequent Sneezing | 1 2 3 4 5 |
| Itchy/Watery Eyes | 1 2 3 4 5 |
| Drainage | 1 2 3 4 5 |
| Earache or Ear Infection | 1 2 3 4 5 |
| Itching | 1 2 3 4 5 |
| Hoarseness | 1 2 3 4 5 |
| Shortness of Breath | 1 2 3 4 5 |
| Wheezing | 1 2 3 4 5 |

**Muscular/Skeletal**

| | |
|---|---|
| Muscle Aches | 1 2 3 4 5 |
| Fibromyalgia | 1 2 3 4 5 |
| Arthritis | 1 2 3 4 5 |
| Joint Pain | 1 2 3 4 5 |
| Low Back Pain | 1 2 3 4 5 |
| Neck Pain | 1 2 3 4 5 |
| Wrist/Hand Pain | 1 2 3 4 5 |
| Elbow Pain | 1 2 3 4 5 |
| Shoulder Pain | 1 2 3 4 5 |
| Hip Pain | 1 2 3 4 5 |
| Knee Pain | 1 2 3 4 5 |
| Ankle/Foot Pain | 1 2 3 4 5 |
| Pain b/t shoulder blades | 1 2 3 4 5 |

**Neurological**

| | |
|---|---|
| Headaches | 1 2 3 4 5 |
| Migraines | 1 2 3 4 5 |
| Malaise | 1 2 3 4 5 |
| Dizziness | 1 2 3 4 5 |
| Numbness | 1 2 3 4 5 |
| Tingling | 1 2 3 4 5 |
| Pins/needles in hands or feet | 1 2 3 4 5 |

**General**

| | |
|---|---|
| Fatigue | 1 2 3 4 5 |
| Weakness, tiredness | 1 2 3 4 5 |
| Lightheadedness | 1 2 3 4 5 |
| Irritability | 1 2 3 4 5 |
| Constipation | 1 2 3 4 5 |
| Diarrhea | 1 2 3 4 5 |
| Forgetfulness | 1 2 3 4 5 |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date