Patient ID #: _____

Patient Intake Form

Patient Data **Date: _____**

Title: (Check one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

First Name _____ Middle Initial _____Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ **Work Phone (_____) _____-_____**

Cell Phone (_____) _____-_____ **Email _____**

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Social Security Number: _____-_____-_____ **Marital Status:** □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Retired

Language: □English □Spanish

Race: □American Indian or Alaska Native □Asian □White □Black or African American

□Native Hawaiian or Other Pacific Islander □Declined to specify

Ethnicity: □Hispanic □Non-Hispanic

Employer Data

Employer/Company Name_____

Your Occupation _____Start Date(approx.) _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Patient ID #: _____

Patient Name_____Date_____

Surgeries: (Check all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia

□ **NONE** Other _____

Allergies: (Check all that apply to you)

□ Eggs	□ Fish and Shellfish	□ Milk or Lactose	□ Peanuts
□ Soy	□ Sulfites	□ Wheat/Glutens	

□ **NONE** Other: _____

Social History: (Check all that apply to you)

Lives:	□Live alone	□ Lives with spouse	□ Lives with_____		
Cigarettes:	□Current everyday	□ Current someday	□ Former	□ Chew Tobacco	□ **never**
Caffeine use:	□ < 3 drinks/day	□ 3-6 drinks/day	□ > 6 drinks/day	□ **none**	
Drink Alcohol:	□ Casual	□ Moderate	□ Heavy	□ **none**	
Exercise:	□ daily	□ weekly	□ never		
Drug Use:	□ recreational use	□ addiction	□ **none**		

Family History: (Check all that apply)

Arthritis:	□ Mother	□Father	□ Maternal Grandparent	□Paternal Grandparent
Cancer:	□ Mother	□ Father	□ Maternal Grandparent	□Paternal Grandparent
Diabetes:	□Mother	□ Father	□ Maternal Grandparent	□Paternal Grandparent
Heart Disease	□ Mother	□ Father	□ Maternal Grandparent	□Paternal Grandparent
Hypertension	□Mother	□ Father	□ Maternal Grandparent	□Paternal Grandparent
Stroke	□ Mother	□ Father	□ Maternal Grandparent	□Paternal Grandparent
Thyroid	□ Mother	□ Father	□ Maternal Grandparent	□Paternal Grandparent

□ **NONE** Other _____

Occupational Activities: (Check one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper

□ **NONE** Other _____

Patient ID #: _____

Patient Name_____Date_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing				**Ear, Nose and Throat**	Past	Present	No
Pace Maker								Difficulty Swallowing			
Jaw Pain				**Eyes**	Past	Present	No	Dizziness			
Irregular Heartbeat				Glaucoma				Hearing Loss			
Swelling of legs				Double Vision				Sore Throat			
				Blurred Vision				Nosebleeds			
Genitourinary	Past	Present	No					Bleeding Gums			
Kidney Disease				**Psychiatric**	Past	Present	No	Sinus Infections			
Burning Urination				Depression							
Frequent Urination				Anxiety				**Gastrointestinal**	Past	Present	No
Blood in Urine				Stress				Gall Bladder Problems			
Kidney Stones								Bowel Problems			
Lower Side Pain				**Endocrine**	Past	Present	No	Constipation			
				Thyroid				Liver Problems			
Neurologic	Past	Present	No	Diabetes				Ulcers			
Stroke				Hair Loss				Diarrhea			
Seizures				Menopausal				Nausea/Vomiting			
Head Injury				Menstrual				Bloody Stools			
Brain Aneurysm								Poor Appetite			
Numbness				**Hematologic**	Past	Present	No				
Severe Headaches				Hepatitis				**Musculoskeletal**	Past	Present	No
Pinched Nerves				Blood Clots				Gout			
Parkinson's				Cancer				Arthritis			
Carpal Tunnel				Bruising				Joint Stiffness			
Vertigo				Bleeding				Muscle Weakness			
				Fever, Chills				Osteoporosis			
Constitutional	Past	Present	No	Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

_____

Please list your other health care providers (PCP, specialists, etc.)_____

_____

Doctor's Signature _____

Patient ID #: _____

Patient Name_____Date_____

Payment/Insurance Information: You must supply a copy of your insurance card in order to file your claims. If you are NOT the policy holder please fill in NAME and DOB

Personal Health Insurance Carrier □ BCBS □ Cigna □ Medcost □ Medicare
□Humana □Other _____

Policy Holder's Name: _____

Policy Holder's Date of Birth _____ / _____ / _____

I give permission for Lillington Family Chiropractic, P.A. to file my insurance.

Print Patient's Name _____

Patient's Signature _____ Date_____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian/Spouse Signature _____Date_____

Patient ID #: _____

I give permission to Lillington Family Chiropractic, P.A. to discuss the following medical and billing information about me (check all boxes that apply):

□ Scheduling/appointment information
□ Medical information including: my history, symptoms, diagnosis, medications, and treatment plan.
This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning.
□ Examination results
□ Billing and payment information
□Other:_____

Lillington Family Chiropractic, P.A. has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may cancel this permission at any time (by writing to Lillington Family Chiropractic, P.A), but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:
□ When I cancel it in writing
□ _____ (specify date)
If no expiration date is specified, this authorization will remain in effect until Lillington Family Chiropractic, P.A. receives written notice to cancel it.
□ I decline permission to verbally discuss medical information.

Patient Signature: _____Date: _____

Signature of legal guardian: _____ Date: _____

Relationship to patient: _____