Hollis Family Chiropractic Center, PLLC

New Patient Intake Form

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About You

Last Name: ______________________ First Name: _______________________ Middle Initial: _______
Nickname: _________________________________ Occupation: __________________________________
Date of Birth: _____________ Age: __________ Gender: [ ] Male [ ] Female
Phone: (H)_________________ (W)_________________ (C)______________________
Address: ____
City: _____________________ State: ______ Zip: ___________ E-Mail:__________________________
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other: _______________________
Spouse's Name: ______________________________
Names and Ages of Children:
____
Insurance: [ ] Work Comp [ ] Auto [ ] MA [ ] Medicare [ ] Private: _______________________________
Emergency Contact: _________________________ Phone #: _____________ Relationship: _________
Who may we thank for referring you to us? ____
[ ] Yellow pages [ ] Lecture [ ] Drive by [ ] Coupon [ ] Website [ ] Other ________________________
[ ] Screening Where?: _____________________ [ ] Mailing Which one?: ______________________

Your Health Profile

Why is this form important? As a family chiropractic office, we focus on your ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services.

Describe the issues that brought you to our office: _____________________________________
____
____

Briefly describe the chief area of complaint, including the effect it has on you:
____
____

If you have no symptoms or complaints and are here for ***wellness services***, please check ☐

What are your health goals? ____
____
____

Is your current condition the result of: [ ] an auto accident? [ ] a work related injury?
Date of injury? _______________

Have you had previous chiropractic care? [ ] Y [ ] N

If yes, what was the doctor's name? ____

What was the approximate date of your last visit? ____

How long have you been receiving care from this chiropractor?_____________________________________

Do you have a family physician? [ ] Y [ ] N

Name of physician____
Address____
Phone #____

May we share information with your physician regarding our findings, conclusions and recommendations for care?
[ ] Y [ ] N

Please describe below, in the following 3 sections, your primary, secondary and additional reasons for seeking care in our office:

Primary complaint (List one only): ____

When did you first experience this problem?____

If your complaint is the result of an injury, describe what happened? ________________________________
____
____

How often do you experience this problem? [ ] 1-2x/week [ ] 3-4x/week [ ] 5-6 x/week [ ] daily
[ ] other: ____

On a scale of 0-10 with 10 representing the most severe pain imaginable, rate the severity of your pain.
0 1 2 3 4 5 6 7 8 9 10

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)
0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? [ ] Y [ ] N

When? ____

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc.)? __________________
____
____

Please describe the location of the pain: ____
____

Does this problem cause pain to travel to any other area?: [ ] Y [ ] N If yes, where?____________
____
____

Is this problem getting: [ ] worse? [ ] better? [ ] staying the same?

What seems to aggravate this problem?____
____

What have you tried to relieve this problem (i.e. interventions, treatments, medications, surgery)?
____
____
____

Have you seen any other doctors for this problem? [ ] Y [ ] N If yes, who? ____________________
____

What treatment was given? ____

How effective was the treatment? ____

Secondary Complaint (List one only): ____

When did you first experience this problem? ____

How did this problem first begin? ____
____
____

How often do you experience this problem? [ ] 1-2x/week [ ] 3-4x/week [ ] 5-6 x/week [ ] daily
[ ] other: ____

On a scale of 0-10 and 10 representing the most severe pain imaginable, rate the severity of your pain.
0 1 2 3 4 5 6 7 8 9 10

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)
0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? [ ] Y [ ] N

When? ____

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc)? _________________
____
____

Please describe the location of the pain: ____
____
____

Does this problem cause pain to travel to any other area?: [ ] Y [ ] N If yes, where?_________
____
____

Is this problem getting: [ ] worse? [ ] better? [ ] staying the same?

What seems to aggravate this problem? ____
____

What have you tried to relieve this problem (i.e. interventions, treatments, medications, surgery)?
____
____

Have you seen any other doctors for this problem? [ ] Y [ ] N If yes, who? ______________
____

What treatment was given? ____

How effective was the treatment? ____

Additional Complaints – *(List anything else you'd like to discuss with the doctor):*
____

When did you first experience this problem? ____

How did this problem first begin? ____

How often do you experience this problem? ____

When did these symptoms begin? ____

How would you describe the symptoms? ____

Please describe the location of the pain: ____

Is this problem getting: [ ] worse? [ ] better? [ ] staying the same?

What seems to aggravate this problem?____

What have you tried to relieve this problem? ____

Have you seen anyone for this problem? If yes, who? ____________________________________

What treatment was given? ____

How effective was the treatment? ____

Lifestyle/Social History

What physical activities do you perform at work? (example: prolonged sitting, computer/desk, lifting, prolonged standing, etc…) ____
____
____

How many hours per week do you work? ____

What recreational activities/hobbies do you regularly engage in? _____________________________
____
____
____

Do you smoke cigarettes? [ ] Y [ ] N If yes, how much? __________________________________
Do you drink alcohol? [ ] Y [ ] N If yes, how much? ____________________________________
Do you drink coffee? [ ] Y [ ] N If yes, how much? _____________________________________
Do you drink tea? [ ] Y [ ] N If yes, how much? ____
How regularly do you exercise? [ ] daily [ ] _____x/week [ ] occasionally [ ] never

What kind of exercise do you do?____

How many hours of sleep do you get on average?____

On a scale of 0-10 please rate your stress level (0=none and 10=extreme):
Occupational _____
Personal _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
________________________	____
________________________	____
________________________	____
________________________	____

When was your last period? ____
Are you pregnant? [ ] Yes [ ] No [ ] Not sure

Medical History

Please check any of the following illnesses you have had:

_____ Anemia	_____ Diabetes	_____ Influenza	_____ Pneumonia	_____ Rheumatic Fever
_____ Arthritis	_____ Eczema	_____ Measles	_____ Polio	_____ Mental Disorders
_____ Cancer	_____ Epilepsy	_____ Mumps	_____ Pleurisy	_____ Tuberculosis
_____ Chicken Pox	_____ Heart Disease	_____ Lumbago	_____ Small Pox	_____ Thyroid Disorder
				_____ Whooping Cough

Surgeries:

Date	Type and reason for surgery
__________________	____
__________________	____
__________________	____
__________________	____

Previous injuries or trauma (please give type and date): _____________________________________
____
____
____

Medications:

Medication	Reason for taking
________________________	____
________________________	____
________________________	____
________________________	____

Nutritional Supplements You Are Currently Taking:
____
____
____

Allergies: ____
____
____

Please check any of the following you have experienced:

MUSCULO-SKELETAL
_____ Low Back Pain
_____ Pain Between Shoulders
_____ Neck Pain
_____ Arm Pain
_____ Joint Pain/Stiffness
_____ Walking Problems
_____ Difficult Chewing/Clicking Jaw
_____ General Stiffness

NERVOUS SYSTEM
_____ Nervous
_____ Numbness
_____ Paralysis
_____ Dizziness
_____ Forgetfulness
_____ Confusion/Depression
_____ Fainting
_____ Convulsions
_____ Cold/Tingling Extremities
_____ Stress
_____ Hearing Difficulty

GASTRO-INTESTINAL
_____ Poor/Excessive Appetite
_____ Excessive Thirst
_____ Frequent Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Liver Problems
_____ Gall Bladder Problems
_____ Weight Trouble
_____ Abdominal Cramps
_____ Gas/Bloating after Meals
_____ Heartburn
_____ Black/Bloody Stools
_____ Colitis

GENITO-URINARY
_____ Bladder Trouble
_____ Painful/Excessive Urination
_____ Discolored Urine

CARDIO-VASCULAR-RESPIRATORY
_____ Chest Pain
_____ Short Breath
_____ Blood Pressure Problems
_____ Irregular Heartbeat
_____ Heart Problems
_____ Lung Problems/Congestion
_____ Varicose Veins
_____ Ankle Swelling
_____ Stroke

EENT
_____ Vision Problems
_____ Dental Problems
_____ Sore Throat
_____ Ear Aches
_____ Stuffed Nose

MALE/FEMALE
_____ Menstrual Irregularity
_____ Menstrual Cramps
_____ Vaginal Pain/Infection
_____ Breast Pain/Lumps
_____ Prostate/Sexual Dysfunction
_____ Other Problems:
____
____
____

GENERAL
_____ Fatigue
_____ Allergies
_____ Headaches
_____ Fever

Please give us any other health information you may feel would be helpful: ____________________________
____
____

Authorizations and Releases

Patient's name: _________________________________ Date of Birth: _____________

Authorization and Agreement for Payment of Services Rendered:

I authorize Hollis Family Chiropractic Center, PLLC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claims for reimbursement of charges incurred by me.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account upon receipt.

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient's signature: _______________________________________ Date: ________________

Informed Consent for Examination and Treatment

This document explains some potential risks associated with chiropractic care. Please read this information carefully, and let our staff know if you have questions.

The doctor and staff of Hollis Family Chiropractic Center, PLLC will do everything to assist you with your health, or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem. While Chiropractic care is remarkably safe, there are some risks associated with it, and we feel you need to be fully informed about these risks before consenting to treatment.

Soreness – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please advise your doctor if you experience this.
Soft Tissue Injury – Rarely, Chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.
Rib Injury – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.
Stroke – Stroke is the most serious complication of Chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of this type of stroke is one in five million neck adjustments.
Other Complications – There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctor and staff of Hollis Family Chiropractic Center, PLLC to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

____________________________ _________ ____
Patient's Name Date Signature (Parent or guardian, if patient under age 18)