DESROCHES CHIROPRACTIC, PLLC

New Patient Intake Form

How did you hear about our office?_____

Name: □ Mr. □ Mrs. □Ms. □ Miss □ Dr.
First: _____ Middle Initial: _____
Last: _____

Address:_____
City:_____State:_____
Zip Code: _____

Home Phone: ( ) _____-_____
Work Phone: ( ) _____-_____
Cell Phone: ( ) _____-_____
Email:_____
Date of Birth: _____/_____/_____
Sex: □ Male □ Female
Marital Status: □ Single □ Married □ Other

Employment Status:
□ Employed □ Unemployed □ Student
□ Other _____
Your Occupation:_____
Your Job Description:_____

Emergency Contact:
Contact Name:_____
Relationship to Patient:_____
Contact Home Phone: ( ) _____-_____
Cell Phone: ( ) _____-_____

Medical Conditions: (Check all that apply to you)
□ Arthritis □ Cancer
□ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness
□ Skin Disorder □ Stroke
□ Other _____

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
□ Other _____

Allergies: (Check all that apply to you)
□ Eggs □ Fish and Shellfish
□ Milk or Lactose □ Peanuts
□ Soy □ Sulfites
□ Wheat/Glutens □ Other _____

Social History: (Check all that apply to you)
Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often □ never
Exercise: □ occasional □ often □ never
Chew Tobacco: □ occasional □ often □ never
Cigarettes: □<1 pack/day □ >1 pack/day □ never

Family History: (Check all that apply)
Arthritis: □ Parent □ Sibling □ Grandparent
Cancer: □ Parent □ Sibling □ Grandparent
Diabetes: □ Parent □ Sibling □ Grandparent
Heart Disease □ Parent □ Sibling □ Grandparent
Hypertension □ Parent □ Sibling □ Grandparent
Stroke □ Parent □ Sibling □ Grandparent
Thyroid □ Parent □ Sibling □ Grandparent

Occupational Activities:
(Check one that best describes your job description)
□ Computer User □ Heavy Equipment
□ Daycare/Childcare □ Construction
□ Health Care □ Food Service Industry
□ Heavy Manual Labor □ Light Manual Labor
□ Housekeeper □ Other _____

List all Current Medications:
_____
_____
_____
_____
_____

Are you pregnant? Yes_____ No _____N/A_____

Who is responsible for your bill?
□ Health Insurance □ Self □ Spouse
□ Worker's Comp □ Auto Insurance
□ Medicare □ Medicaid
□ Other _____

Health Insurance: _____
Insurance Card ID #: _____
Group #: _____
Policy Holder's Name:_____
Policy Holder's Date of Birth _____ / _____ / _____

Primary Care Physician:_____

Worker's Compensation Injury / Auto / Personal Injury:

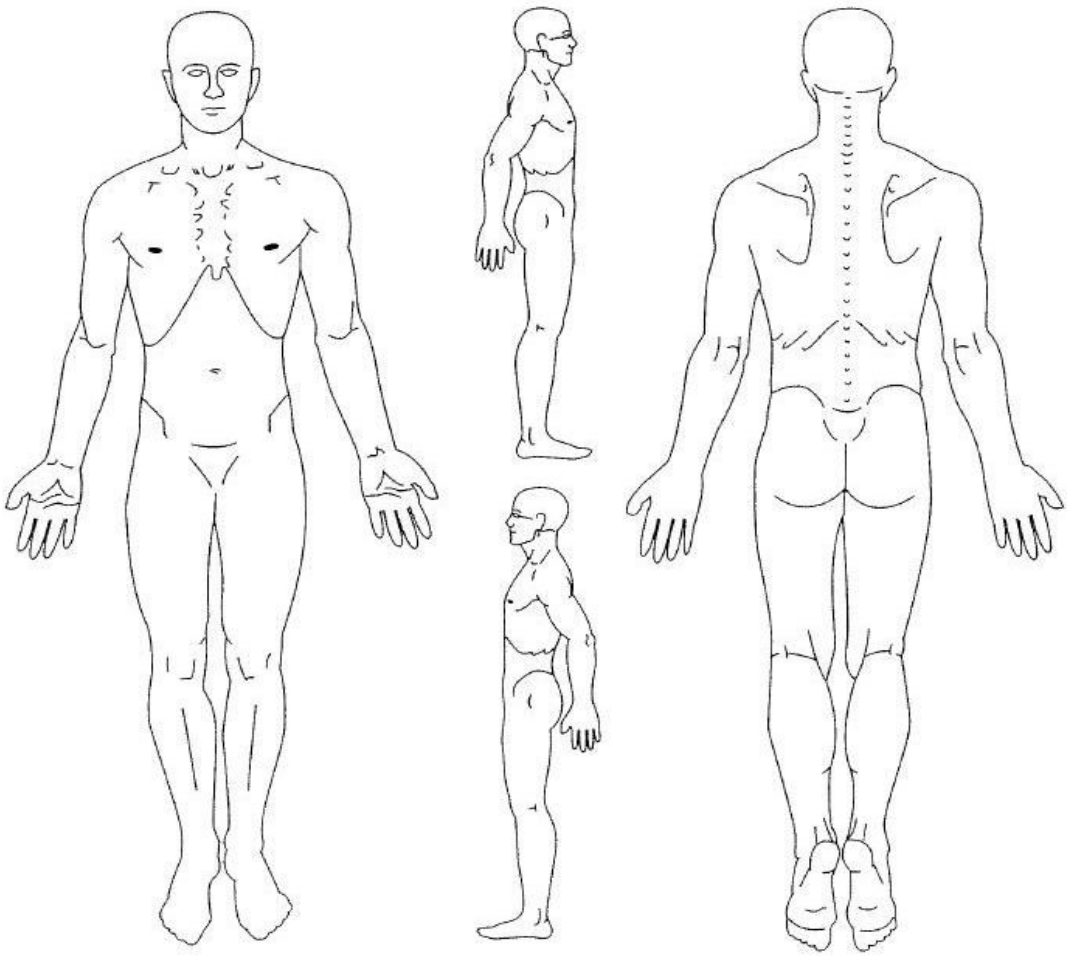
Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

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

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

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Are your symptoms a result of: □ Motor Vehicle Accident □Work Related Accident
□ Other:_____

How did your symptoms begin? _____
_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp □ Dull ache □ Numb □ Shooting
□ Burning □ Tingling □ Stabbing □ Other _____

How are your symptoms changing?

□ Getting better □ Not changing □ Getting worse

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's Signature Authorizing Care:_____

Date: _____

SIGNATURE OF PHYSICIAN: _____ Date: _____