

Jaffrey Chiropractic – New Patient Intake Form

Today's Date _____

Name _____ Address _____

Apt.# _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Age _____ Birth Date _____ Marital: **S M D W** How many children? _____

E-Mail _____ Referred By _____

Occupation _____

Employer _____ Address _____

Name of Spouse _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____ Other Phone _____

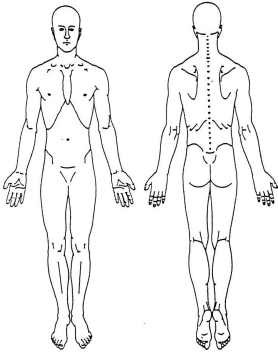
Are you Insured? YES NO Insurance Company _____

Person Responsible For Payment if other than Patient (Policy Holder Information)

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ Zip _____

Confidential Health History



Please outline on the diagram to the left, the area of your discomfort/pain. Then, describe your present complaints below.

Is this a work related injury? YES NO

When did your present complaints occur? _____ Describe _____

Who has treated you for this condition (if anyone)? _____

Have you been treated for any other health condition this last year? YES NO _____

Is this condition interfering with your Work Sleep Recreation? Dates missed: _____

Have you had this condition or similar conditions in the past? YES NO If so, when? _____

What treatment did you receive? _____

Name & location of previous chiropractor: _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto/Motorcycle accidents: _____ Surgeries: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken bones: _____ Knocked unconscious: _____

Do you smoke? ___ YES # _____ pks/day ___ NO ___ Quit _____

Do you drink alcohol? ___ YES How much? _____ ___ NO

Please check any of the following that apply to your current or past medical history:

- | | | | |
|---------------------------------------------------|-------------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio | <input type="checkbox"/> Dentures | <input type="checkbox"/> Eczema/Hives |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sprained ankle | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Vomiting of blood | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Depression | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Low backache | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Painful tail bone | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Surgery | <input type="checkbox"/> Numbness in arms/hands |
| <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Stiff or painful neck | <input type="checkbox"/> Weakness in arms | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Bad posture | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Burning sensations | |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Enlarged Glands | | |
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Gout | | |
| <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Nasal congestion | | |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Itching | | |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Chronic cough | | |
| <input type="checkbox"/> Poor urine control | <input type="checkbox"/> Heart disease | | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Hemorrhoids | | |
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Cancer | | |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Belching or gas | <input type="checkbox"/> Chest pain | | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting | | |
| <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Broken bones | | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness in legs | | |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Rheumatic fever | | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sinus infection | | |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Convulsions | | |

For Women Only:

- | | |
|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Premenstrual tension | <input type="checkbox"/> Unable to get pregnant |
| <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Excessive flow | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Irregular cycle |

Is there a possibility that you may be pregnant? ___ YES ___ NO

Date of last menstrual period _____

Is There Anything Else We Should Know? _____

I agree that I have answered the questions on this form truthfully to the best of my knowledge.

Patient's /Guardian's Signature _____ Date _____

INSURANCE ASSIGNMENT AUTHORIZATION PLEASE HAVE YOUR INSURANCE CARD READY SO THAT WE MAY PHOTOCOPY IT

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original.

1. I assign to JOSHUA J. HIRSCH, D.C. (Jaffrey Chiropractic) my insurance benefits and I authorize Jaffrey Chiropractic to give my insurance company all of the information pertaining to my case that they request in order to make payment.

2. You are responsible for your co-payment or co-insurance at time of services rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Jaffrey Chiropractic Health Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to JOSHUA J. HIRSCH, D.C. will be to my account on the receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's/Insured's Signature _____ Date _____