

CCC Chiropractic New Patient Intake Form

Patient Data

Date _____

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

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

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 Other _____

Spouse Data

First Name _____ Middle Initial ____ Last Name _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Employer Data

Name _____

Your Occupation _____ Your Job Description _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

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

Doctor's Signature _____

Patient Name _____

Date _____

How did you hear about our office? _____

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 |
| Wear Seat Belts: | occasional | always | never |
| Other _____ | | | |

Family History: (Check all that apply)

| | | |
|---------------|--------|---------|
| Arthritis: | Parent | Sibling |
| Cancer: | Parent | Sibling |
| Diabetes: | Parent | Sibling |
| Heart Disease | Parent | Sibling |
| Hypertension | Parent | Sibling |
| Stroke | Parent | Sibling |
| Thyroid | Parent | Sibling |
| 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 |
| Other _____ | | | |

Doctor's Signature _____

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 | | | | | | | |
| 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 | | | | | | | | | | | |

Please list all current medications being taken _____

Doctor's Signature _____

Patient Name _____

Date _____

Are you pregnant? Yes _____ No _____ N/A _____

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

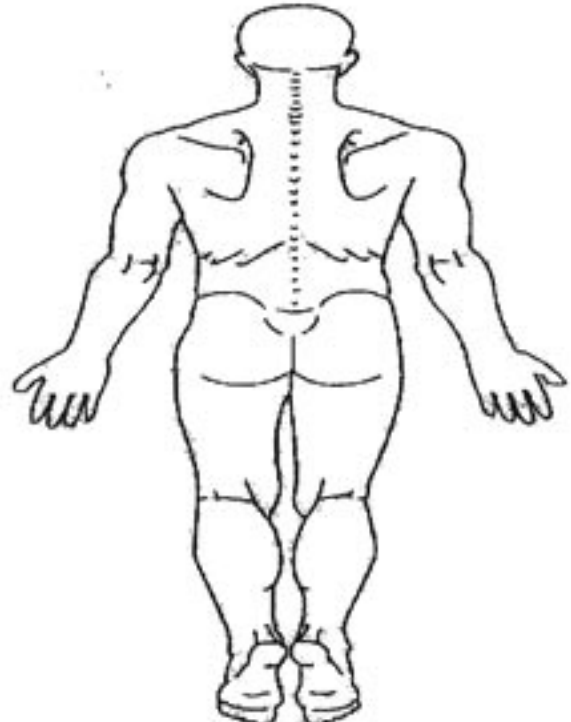
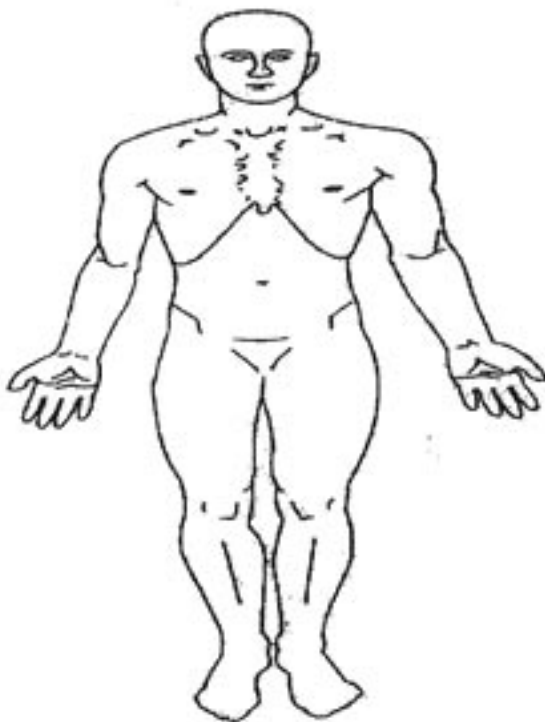
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? Month _____ Day _____ Year _____

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
Burning

Dull ache
Tingling

Numb
Stabbing

Shooting
Other _____

Doctor's Signature _____

Patient Name _____

Date _____

How are your symptoms changing?

Getting better

Not changing

Getting worse

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ Score _____

Description of Work: _____

Condition's Effect On Job Performance: No Effect Mild (painful can do) Mod (painful limited ability)
 Mod/Sev (limited duty) Sev (no limited duty) Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn–Sit–Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

Doctor's Signature _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/21/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓢ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- Ⓢ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- Ⓢ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- Ⓢ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- Ⓢ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- Ⓢ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- Ⓢ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- Ⓢ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- Ⓢ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- Ⓢ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev. 3/21/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓩ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓩ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓩ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓩ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓩ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓩ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓩ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓩ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓩ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓩ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Patient Name

Date

Payment/Insurance Information:

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

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

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

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:** _____