New Patient Intake Forms

Delanghe Chiropractic & Health
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General Information

Patient Name:_____ Birthdate (mm/dd/yyyy):_____ Gender: M F

Current Address:_____ City:_____ Postal Code:_____

Phone- Home:_____ Cell:_____ Work:_____

E-mail address:_____

☐ Please check if you would like to be ***excluded*** from office e-mail communications.

Have you been to a chiropractor before? □YES □NO If yes, when was your last visit?_____

Who is your medical doctor?_____

Medical History

Reason for appointment/chief complaint? _____
_____

Do you suffer from any medical conditions (i.e. cancer, diabetes, arthritis, allergies, depression, alcoholism, high blood pressure, cardiovascular disease, high cholesterol, osteoporosis, strokes, back pain, headaches, neck pain). Please list:
_____
_____

Have you ever undergone any surgeries? Please list with the year conducted:_____
_____

Have you ever suffered from a medical condition that you have now recovered from? Please list:
_____

Are you currently using any medications? Please list: _____
_____

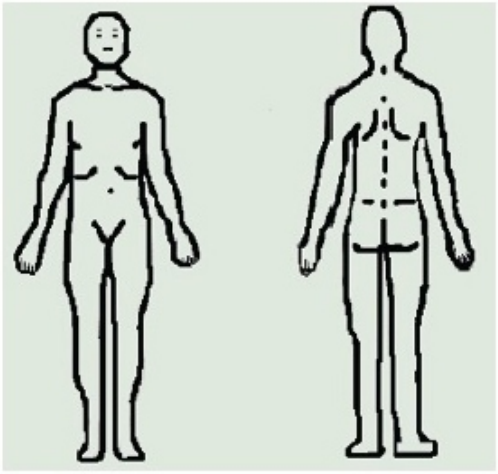
Are you currently using any nutritional supplements? Please list: _____
_____

Please list medical conditions that family members have suffered from, or continue to suffer from (i.e. cancer, diabetes, arthritis, allergies, depression, high blood pressure, cardiovascular disease, high cholesterol, osteoporosis, strokes, back pain, headaches, alcoholism, neck pain) _____

_____

For your CURRENT complaint, please complete the following pain diagram. Place the appropriate letters over the regions where you are experiencing symptoms:

Dull Ache	(A)
Sharp	(H)
Tingling	(T)
Numbness	(N)
Burning	(B)
Stiffness	(F)
Tight	(G)
Other:	(X)



Please circle the number that indicates your current pain level:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

When did this condition begin? _____ Has it happened before? _____

How did it happen?_____

Does the pain spread out to other areas? Explain._____

What aggravates the symptoms?_____

What relieves the symptoms?_____

Have you sought treatment elsewhere for this condition? _____

If yes, what was the treatment and results?_____

Have you noticed any secondary complaints or conditions? _____

_____

General Lifestyle

Do you smoke?_____ If yes, how much/week?_____

Do you consume alcohol?_____ If yes, how many drinks/week?_____

Do you exercise?_____ If yes, how often?_____

Are you satisfied with your current diet?_____

Office Policies

Welcome to our clinic. We want you to understand and consent to the services we provide and the costs involved. If you have questions, please ask.

Our expectations of patients for services rendered:

- We expect patients to pay for all services rendered when they are provided. If you do not pay for a service at the time it is received, patients are expected to pay interest on any outstanding balance at the rate of 3%/month and then pay the costs of recovering debt (i.e. legal and/or agent costs).
- We expect patients to provide 24 hours notice when cancelling an appointment. Your appointment time is reserved exclusively for you, and thus the time cannot be used to see other patients without being given sufficient notice. If you cancel outside of this 24 hour period, you agree to pay the appointment value in full.
- The current fee schedule for adults is $70 for a new patient examination, $40 for a subsequent treatment, $51 for an extended visit (i.e. involving rehabilitation exercise plans, and multiple body regions), and $54 for new complaints. Please ask about senior, child and student discounts.

Patient Signature:_____ Date:_____

Patient Guardian Signature:_____ Date:_____