HEALTH WAVE CHIROPRACTIC

NEW PATIENT INTAKE FORM

Patient Information:

First Name: _____ Last Name: _____

Preferred Name: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

Street Address: _____

Street Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Date of Birth - Month: _____ Day: _____ Year: _____

Sex: _____

Occupation: _____ Duration: _____

Guardian: _____ Relationship: _____

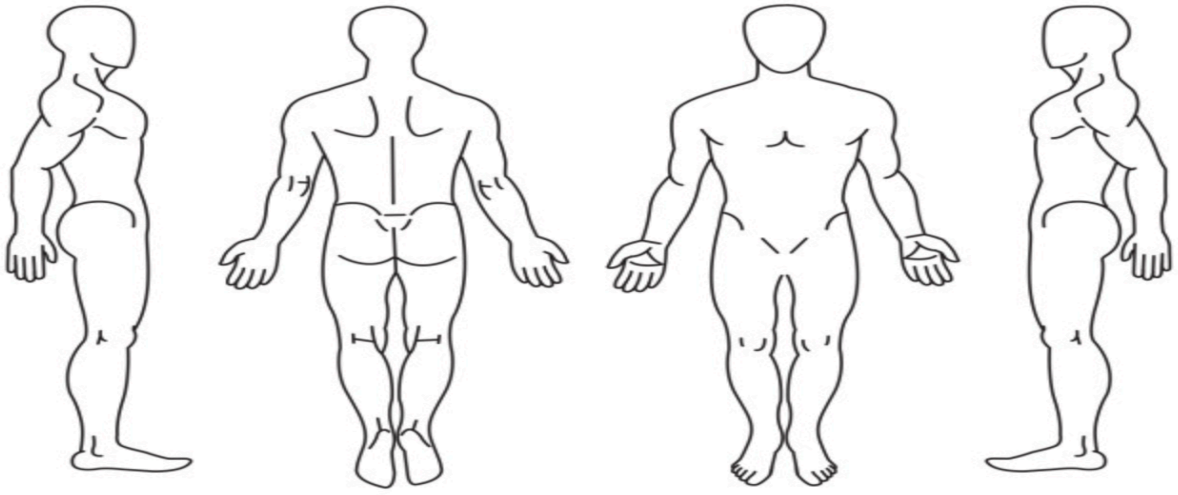
Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

Family Doctor: _____ Doctor phone/email: _____

How Did You Hear About Us? _____

Draw where you are feeling your issue:



Current Condition and History:

- Describe your pain/discomfort in detail:_____

_____

_

- When did it start?: _____
- Current Pain Level (circle one): 0—-1—-2—-3—-4—-5—--6—--7—--8—--9—--10

None mild moderate Severe Hospital

- Highest Pain Level (circle one): 0—--1—-2—-3—-4—-5—--6—--7—--8—--9—--10
- What caused your pain/discomfort? _____

_____

- Pain Description: (check all that apply)

□Aching □Burning □Dull □Sharp □Stabbing □Shooting □Throbbing
□Weakness □Numbness □Tingling □Tension □Stiffness □Radiating □Other
If Other - Describe: _____

- What makes this feel better or What have you tried? (check all that apply)

□Nothing □Chiropractic □Physical Therapy □Massage □Acupuncture
□Stretching □Ice □Heat □CBD □Medication □Other
If Other - Describe: _____

- What Makes Your Pain Worse: (check all that apply)

□Walking □Running □Lifting □Bending Forwards □Bending Backwards □Twisting
□ Sneezing □Coughing □Rest □Overhead Reaching □Using Computer
□Sleeping □Work □Other
If Other - Describe: _____

- Does your pain travel anywhere?

□YES □NO If So, Where?:_____

- Have you had this pain before: (check one)

□YES □NO □Don't Recall

- How often do you feel your pain?

□Never □Occassionally □intermittently □frequently □Constantly □only at night
□only in the mornings □at the end of the day

- Is your pain getting:

□worse □staying the same □better □fluctuating

Health History: (use top or bottom of sheet for any additional info)

General Symptoms: (check all that apply)

□Nervousness □Headaches □Migraines □Fever □Excessive Sweating
□Night Sweats □Night Pain □Generalized Pain □Nervous □Convulsions
□Loss of Sleep □Loss of Consciousness □ Blackouts

Neurological Symptoms: (check all that apply)

□Dizziness □Fainting □Problem □Speaking □Blurred Vision
□Nausea □Numbness □Tingling □Radiating Pain

Eyes / Ears / Nose / Throat: (check all that apply)

□Failing Vision □Vision Problems □Eye Pain □Ringing/Tinnitus □Hearing Loss
□Other Problems Not Listed:_____

Respiratory Symptoms: (check all that apply)

□Asthma □Chronic Cough □Difficulty Breathing □Shortness of Breath
□Bronchitis □Emphysema □COPD □Infection □Other: _____

Cardiovascular Symptoms: (check all that apply)

□Bleeding Disorder □High Blood Pressure □Low Blood Pressure □Stroke
□Cerebral Vascular Accident □Hardening of Arteries □Swelling of Ankles
□Poor Circulation □Angina □Congestive Heart Failure □Heart Attack
□Phlebitis/Varicose Veins □Pacemaker/Similar Device
□Other and Date of Occurrence: _____

Gastrointestinal Symptoms: (check all that apply)

□Jaundice □Irregular Bowel Movement □Absent Bowel Movement □Ulcer
□Diabetes □ Indigestion □Strange Color □Bleeding □Other:_____

Genitourinary Symptoms: (check all that apply)

□Trouble Urinating □Kidney Infection □Kidney Stones □Prostate Trouble

Genitourinary Symptoms: (female only)

□Hot Flashes □Irregular / Absent Cycle □Cramping/Backache

Are You Currently Pregnant? (if yes, how far along and expected due date)

□YES _____
□NO

Health History continued:

Please list any and all surgeries including details and dates:

_____

_

_____

_

Have you ever been admitted to the hospital for any reason? (if yes, date and details)

□YES _____

□NO

Have you ever had any fractures? (if yes, date and details)

□YES _____

□NO

Have you ever been diagnosed with Cancer? (if yes, date and details)

□YES _____

□NO

Have you ever had a Stroke/CVA/TIA? (if yes, date and details)

□YES _____

□NO

Do you have Osteoporosis or Osteopenia?

□YES _____

□NO

Do you have any Pacemakers, defibrillators, spinal stimulators, implant devices, etc?

□YES _____

□NO

Do you suffer from allergies related to seasons, herbs, pets, foods, drugs, or other?

□YES _____

□NO

Family Medical History: (please check all that apply)

□Headaches/Migraines □High Blood Pressure □Diabetes □Heart Disease

□Fainting □Stroke □Circulatory Problems □Cancer □Neurological Disease

□Kidney Disease □Fibromyalgia □Epilepsy □Respiratory Disorders
□Rheumatoid Arthritis □Osteoarthrits □Osteoporosis □Multiple Sclerosis

Lifestyle:

Please describe you physical activity levels, activities you do, hobbies, etc:

_____

_

_____

_

Current Stress Levels:

□None □Low □Moderate □High Due To: _____

Do you Smoke, Drink, or Use Recreational Drugs? (frequency and duration)

□YES _____

□NO

Please provide any additional information you feel is pertinent or that we didn't ask:

_____

_

_____

_____

__

_____

_

Consents:

Appointment Notifications and Reminders:

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

□ I would like email notifications of new, cancelled, and rescheduled appointments

□ Email 2 days before appointment

□ Opt out of email reminders for my appointments

□ Other (please specify): _____

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

□ Text Message (SMS) 2 hours before my appointment

□ Opt out of text reminders for my appointments

□ Other (please specify): _____

Consents Continued:

Accuracy of Information:

□ I certify that the above medical information is truthful and correct to my knowledge.

Privacy and Sharing of Information:

I authorize Health Wave and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

□ I agree

Cancellation Policy:

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the Doctor's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file.

□ I am aware of the Cancellation Policy

Patient Name (print): _____

Patient Signature: ____________________________________

Date: ____