

WELCOME

New Patient Intake Form

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Patient No. _____ S/S _____ - _____ - _____
First MI Last

Address _____ City _____ State _____ Zip _____

Email address: _____

Birth Date _____ Home Phone # _____ Work Phone # _____

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

Your Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or Parent's Name _____ Workplace _____ Work Phone# _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Insurance Information

Do you currently have insurance? No Yes. IF NO for your convenience we accept cash, check, visa, mastercard & discover

Insurance Company Name _____ (please note we do not accept all insurances)

Insurance Card Number _____

Do you have a deductible? _____

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this injury the result of a work related incident or automobile accident? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? Medication Surgery Physical Therapy

(Women) Are you pregnant? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work, etc.)

Do you currently wear orthotics? _____

Do you smoke? Yes No How much per day? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Health History

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- Recent accident such as a fall, whiplash, or blow to the head
- Spinal/back/neck problems
- Muscle spasms
- Restricted movement
- Tingling or numbness of arms, legs, hands or feet
- Headaches or migraines more than once per month
- Sinus problems
- Depression or Anxiety
- Difficulty dealing with stress
- Dizziness or vertigo
- Vision or Hearing problem
- Sleeping trouble
- Breathing trouble or Asthma
- Digestive trouble or Nausea
- Heartburn/Acid Reflux
- Menstrual problems
- Jaw or mouth problem
- Arm, shoulder, elbow or hand problem (circle)
- Leg, hip, knee or foot problem (circle)

DIAGNOSED CURRENT CONDITIONS

- Born with bone or joint disorder
- Degenerative arthritis
- Rheumatoid arthritis
- Compression fracture
- Heart attack or heart disorder
- History of stroke or aneurysm
- Cancer
- Diabetes
- Gout
- Lupus
- Ankylosing spondylitis
- Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- 3 or more months of steroid medications or intravenous drugs (past or present)
- Tuberculosis, Hepatitis or HIV
- Multiple sclerosis
- Thyroid or hormone disorder
- High blood pressure
- Convulsions/epilepsy
- Allergies: _____
- OTHER: _____

CURRENT OTHER ISSUES

- Difficulty swallowing because of neck pain
- Pain or electric shocks in arms or legs when moving neck
- Leg pain worse with exercise
- Numbness of inner thighs
- Back pain with urinary problems
- Severe pain that interrupts sleep
- Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- Poor balance
- Loss of bowel or bladder control
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- Memory loss after injury
- Recent, unexplained weight loss
- Recent progressive muscle weakness or shaking
- Recent or current fever over 102°F

Whole Body Health Questionnaire

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Are you interested in learning about our nutritional services and whole body health program? _____

Consent Form

Consent To Chiropractic

I hereby consent to the performance of examination, diagnosis, adjustments, and other chiropractic procedures on me (or the patient named above, for whom I am legally responsible) by Dr. David Waldman, D.C. and/or other professionals working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. David Waldman, D.C. I understand and I am informed that, in the practice of chiropractic that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I agree that if I suspect any adverse event that I will inform Dr. Waldman I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Dr. David Waldman, D.C is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. David Waldman, D.C may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare. Members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone/email and you are not at home a message will be left on your answering machine.

Assignment of Insurance Payments

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Waldman Chiropractic Office 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 this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

By signing below, I have read, or have had read to me, and agree to the above Consent to Chiropractic, Privacy Policy Assignment of Insurance Payments, and that I certify that my confidential medical information presented is correct to the best of my knowledge.

Patient or Guardian's Signature _____ **Date** _____

Patient's Name (PRINTED) _____