WELCOME TO KORWITTS CHIROPRACTIC CENTER

Patient Intake Form

Today's Date: ______________________

Name________________________________ Gender: Female Male Age___________

Date of Birth___________________________ Social Security____________________________

Marital Status__________________________ Home Address______________________________

Home#_________________________________ City________________State____ Zip_______

Cell #_________________________________ Email__________________________________

Occupation____________________________ Employer______________________________

Employer Address_______________________ City_________________State___Zip________

Business#_____________________________ Student Status (*circle one*) H.S. College FT/PT

Hispanic: *Yes No* Race *(circle one)*: *White African American American Indian/Alaskin Native Asian Multi-racial Native Hawaiin/Pacific Islander Other Unknown/Not reported*

What Health Insurance do you have: PPO HMO HEALTH SAVINGS MEDICARE CASH

Insurance Company_____________________________ Insured's Employer_________________________

Insured's Name__________________________________ Date of Birth_______________________________

Are you covered by more than one insurance company? No Yes If Yes, Name_____________________

How were you referred to our office?____

MEDICAL/FAMILY HISTORY S = SELF M = MOTHER F = FATHER

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F	Condition	S	M	F	Condition	S	M	F	Condition
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	rheumatism	☐	☐	☐	chest pain
☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever	☐	☐	☐	concussion
☐	☐	☐	bowel control loss	☐	☐	☐	serious injury	☐	☐	☐	convulsions
☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble	☐	☐	☐	diabetes
☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis	☐	☐	☐	indigestion
☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease				

Have you been treated by a physician for any health condition in the last year? YES NO

Date of last physical exam___________________________ **Name of Medical Physician**______________________

Are you pregnant? Yes No **If yes, what trimester?** 1 2 3 **What is your due date?** ________________

Have you ever received Chiropractic Care in the past? Yes No

Surgical History:

1. ____ Date:_____________________________
2. ____ Date:_____________________________

ACTIVE MEDICATIONS	ALLERGIC REACTIONS TO MEDICATIONS	NAMES OF VITAMINS

AUTHORIZATION OF ASSIGNMENT & RELEASE/AUTHORIZATION OF BENEFITS:

I authorize payment of insurance benefits directly to this office. I authorize the doctor to release any/all information necessary to communicate with other healthcare provider and payors to secure the payment of benefits. I understand that I am financially responsible for all costs of chiropractic care, regardless of insurance coverage.

Patient Signature____(Parent, if Minor)

Please present your insurance card when returning this form. Payment is expected upon first visit

Patient Intake Form 2

Is your visit today due to a Car Accident? **Yes No** If yes, Date of Accident________________________________
Is your visit today due to a Work Related Injury? **Yes No** If yes, Date of Accident______________________________
If yes to a Car Accident or Work Related Injury, do you have an attorney? **Yes No**
If you have an attorney, please provide Name of Attorney___________________________ Tel_________________________

What is your **main complaint**? ____

How long have you experienced this complaint? _____________________________
Have you had this issue before? Yes No
Have you been treated for this before? Yes No If yes, where? ____
Are you currently taking medications for this? Yes No If yes, ____

Rate the severity of your pain on a scale of **1 (least pain) to 10 (severe pain) TODAY** _____
Rate the severity of your pain on a scale of **1 (least pain) to 10 (severe pain) at its WORST** _____
Type of pain (*circle all that apply*):

Sharp Dull Throbbing Aching Shooting Burning Tingling Numbness Stiffness

What makes it feel better? ____________________________ What makes it feel worse? ____________________________

Do you have **pain** and/or **difficulty** performing any of the following activities: (circle)

Personal Care Lifting Reading Concentrating Work Driving Sleeping
Recreation Walking Sitting Standing Social Life

What is your **secondary complaint**? ____

How long have you experienced this complaint? _____________________________
Have you had this issue before? Yes No
Have you been treated for this before? Yes No If yes, where? ____
Are you currently taking medications for this? Yes No If yes, ____

Rate the severity of your pain on a scale of **1 (least pain) to 10 (severe pain) TODAY** _____
Rate the severity of your pain on a scale of **1 (least pain) to 10 (severe pain) at its WORST** _____
Type of pain (*circle all that apply*):

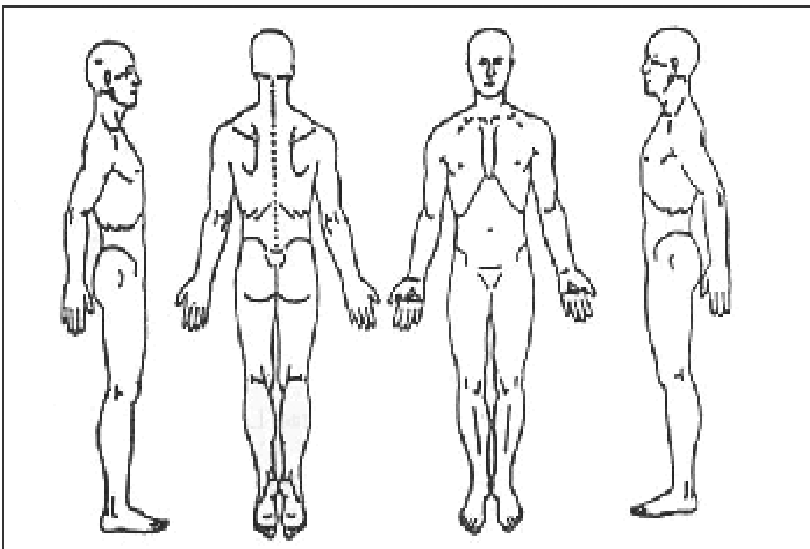
Sharp Dull Throbbing Aching Shooting Burning Tingling Numbness Stiffness

What makes it feel better? ____________________________ What makes it feel worse? ____________________________

Do you have **pain** and/or **difficulty** performing any of the following activities: (circle)

Personal Care Lifting Reading Concentrating Work Driving Sleeping
Recreation Walking Sitting Standing Social Life

On the diagram below, please place an **X** on the areas you are experiencing your present pain/symptoms:



How would you rate your overall health?
Excellent Very Good Good Fair Poor

What type of exercise do you do?
Strenuous Moderate Light None

Smoking Status:
Never Current Former Occasional Unknown

Everything I have stated here on these forms are true to my knowledge. I authorize Korwitts Chiropractic Center and all its staff to provide necessary care based on the info I have provided.

____
Patient Signature (Parent if Minor)

Today's Date_____________________________