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Patient Registration and History

Please take a moment to complete the following intake form so we may obtain all necessary information in regard to your care.
If you have any questions please ask our office staff for assistance.

General Information		Date ____/____/____
Last Name _____	First Name _____	MI _____
Preferred Name (nickname) _____	Date of Birth ____/____/____	Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address _____	City _____	State _____ Zip _____
Home Phone (____) _____	Cell Phone (____) _____	Email _____
Social Security # _____	Employer/School _____	Work Phone (____) _____
Occupation _____	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Spouse/Partner's Name _____		Phone (____) _____
Emergency Contact _____ <small>(other than above)</small>	Relation _____	Phone (____) _____
Referred by _____		

Insurance Information <small>(please present all insurance cards for photo copying)</small>	
Current Health Insurance Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Health Insurance/Other <input type="checkbox"/> None	
Primary Insurance Carrier _____	Name of Insured _____
Relation _____	Insured DOB _____ Health Savings/Reimbursement account? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, Secondary Insurance Carrier _____	
Name of Insured _____	Relation _____ DOB _____
Is current condition related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes if yes please provide date of accident _____	
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other _____	
To who have your made report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Other _____	
Accident/Injury Insurance _____	Claim # _____
Attorney _____	Phone _____

This form is the property of Fortin Chiropractic Health & Wellness Clinic, PA and is placed on the website for our patient's convenience.
Use other than by our patients is expressly prohibited.

Reason for Visit (Please describe the reason for your visit today)

Chief Complaint _____ (others may be checked on the following page)

Approximate date symptoms began _____ Have you had a similar condition in the past? Yes No

Have you received treatment for the above in the past? Yes No Type of treatment _____

Have you had x-rays or scans in the past 6 months in regard to the above? Yes No If yes please list date and type below:

Below are lists of diseases and symptoms which may appear unrelated to the purpose of your appointment. However, please answer the questions carefully as such problems can have an effect on your overall course of chiropractic care:

Please check any of the following diseases you have past or present or check **NONE** if none of the following apply:

- | | | | | |
|---|--|---------------------------------------|--|--------------------------------------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | None <input type="checkbox"/> |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eating Disorder | |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Crohn's Disease | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other (please list) _____ | |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | _____ | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | _____ | |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Eczema | _____ | |

Please place a check next each of the following that apply to your **current** condition:

If none apply please check **NONE** where appropriate

MUSCULOSKELETAL

- None**
- Neck pain
 - Pain between shoulders
 - Low back pain
 - Shoulder pain
 - Arm pain
 - Leg pain
 - Joint pain or stiffness
 - Problems walking
 - Swelling of hands or feet
 - Muscle Cramps
 - General Stiffness
 - Jaw pain/clicking

NEUROLOGIC/PSYCHIATRIC

- None**
- Numbness
 - Paralysis
 - Dizziness
 - Forgetfulness
 - Confusion
 - Depression/Anxiety
 - Fainting
 - Convulsions
 - Cold/Tingling Extremities
 - Stress

GASTRO-INTESTINAL

- None**
- Lack of Appetite
 - Excessive Appetite
 - Frequent Nausea
 - Vomiting
 - Excessive Thirst
 - Diarrhea
 - Constipation
 - Hemorrhoids
 - Frequent Gas/Bloating
 - Heartburn
 - Black/Bloody Stool
 - Colitis
 - Liver Problems
 - Gall Bladder Problems
 - Abdominal Cramps
 - Weight loss/gain

GENITOURINARY

- None**
- Bladder Problems
 - Painful Urination
 - Excessive Urination
 - Discolored Urine

CARDIOVASCULAR/RESPIRATORY

- None**
- Chest Pain
 - Shortness of Breath
 - High Blood Pressure
 - Low Blood Pressure
 - Irregular Heart Beat
 - Heart Disease
 - Lung Problems/Congestion
 - Varicose Veins
 - Ankle Swelling
 - Stroke

ENT

- None**
- Vision Problems
 - Dental Problems
 - Sore Throat
 - Ear Aches
 - Hearing Loss
 - Sinusitis

GENERAL

- None**
- Fatigue
 - Allergies
 - Difficulty Sleeping
 - Fever
 - Frequent Headaches
 - Migraine
 - Weight Gain/Loss
 - Rashes
 - Hair Loss
 - Excessive Dry Skin
 - Currently Pregnant**
 - Breast Feeding**

OTHER please list any additional symptoms here: _____

Past Medical History (please describe and list each date of occurrence)

Major Surgeries _____

Major accidents or falls _____

Hospitalization (other than above) _____

Family and Social History

Daily Habits:

Do you smoke? Yes No if yes, list amount per day _____ if you quit please list date _____

Do you consume alcohol? Yes No if yes, list frequency _____ per _____

Do you consume caffeine? Yes No if yes, list type and amount per day _____

Do you have a high level of stress? Yes No if yes, list main reason _____

Regular Exercise: None Light Moderate Intense Frequency _____ times per _____

Daily work includes: Sitting Standing Light lifting Moderate to heavy lifting Computer work
(check all that apply)

Family Health History:

Please list any significant health issues in your immediate family (mother, father, grandparents, siblings)

Family Member	Health Issue(s)

Medications

Please list below all medications you are currently taking. Please include over the counter and nutritional supplements:

1. _____ for _____
2. _____ for _____
3. _____ for _____
4. _____ for _____
5. _____ for _____
5. _____ for _____
6. _____ for _____
7. _____ for _____
8. _____ for _____
9. _____ for _____

Authorization and Release

Patient Name: _____

I authorize the release of any information concerning my health and health care services, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me under any insurance or pre-paid health plan.

I understand that the benefits quoted by my insurance company are not a guarantee of payment and all charges are considered at the time claims are processed. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I agree to notify your office of any and all insurance changes that would affect the filing of claims or payment for the treatment I receive.

I understand that payment in full is due at the time of service unless other arrangements have been made.

Signature of patient or guardian _____ **Date** _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures that may include but not limited to physical examination, diagnostic testing and x-ray and physical therapy procedures.

I understand with chiropractic treatment, as well as any health care procedures, there are certain risks and complications associated with this type of treatment. Such complications include but are not limited to: post treatment soreness or discomfort, soft tissue injury, dislocation, and fractures. Although rare, some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based on the facts then known, are in my best interest.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment. If you have any questions concerning the above, please ask your doctor of chiropractic.

Having carefully read the above, I give my informed consent to have chiropractic treatment administered.

Signature of patient or guardian _____ **Date** _____

Consent to Treat a Minor (if applicable)

Having carefully read the above, as the parent or legal guardian of _____ I give my informed consent to allow chiropractic treatment to be administered to my child.

Signature of patient or guardian _____ **Date** _____

HIPAA Privacy Practice Acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature of patient or guardian _____ **Date** _____