New Patient Intake Form

Date:_____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address_____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Employer Data_____

Employment Status: Employed Unemployed FT Student PT Student Other_____

Place of Employment_____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact_____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

Referred by:_____

Complaint Information_____

Injury Origin:_____

3000 Latrobe Drive Ste. A Charlotte, NC 28211 P- 980.819.8020 F- 980.819.8545

Describe Discomfort: _____

Frequency:	Always	Hourly	Daily	Occasionally
Interfere with Activities:	Yes	No		
Missed Work/School:	Yes	No		
Affected Appetite:	Yes	No		

Health History _____

Last physical exam: _____

Primary Physician: _____

Broken Bones: Yes No
Explain: _____

Sprains/Strains: Yes No
Explain: _____

Hospitalized: Yes No
Explain: _____

Surgery: Yes No
Explain: _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Depression	Headaches	Stroke
Scoliosis	Pace Maker	Seizures	Sciatica
Other _____			

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Tobacco Use:	occasional	often	never

Other _____

Previous Chiropractic Care: Yes No

Date: _____ **Explain:** _____

Please list all current medications/supplements being taken:

_____

_____

Pregnant: Yes No

Payment/Insurance Information:

Who is responsible for your bill? Self Pay Health Insurance Worker's Comp
Personal Injury Medicare Other _____

Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Performance Rehab Associates Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date _____