PERFORMANCE
REHAB ASSOCIATES
WEST

Dr. Zachary Price, DC FABBIR
Dr. Luke Keane, DC

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:____

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__________________