New Patient Intake

Anderson Family Chiropractic, SC
2911 Tower Ave, Ste 4
Superior, WI 54880

Date: / /

Patient Information:

First Name_____ **Preferred Name** _____

Last Name_____ **Middle Name** _____ **Suffix**_____

Home Phone_____ **Cell Phone**_____

Email_____ **DOB**_____/_____/_____ **Age**____

SSN_____ **Gender:** ☐ **Male** ☐ **Female**

Address:_____ **City/State/Zip**_____

_____

Ethnicity:

☐ Caucasian ☐ Hispanic
☐ African American ☐ Asian/Pacific Islander
☐ Native American ☐ Alaska Native
☐ Other:_____ ☐ Prefer not to answer

Language: _____

Marital Status:

☐ Single ☐ Married ☐ Other

Spousal Information:

Full Name_____
Phone_____
Address ☐ **same as above**

_____
_____

Employment Information: **Status** ☐ FT ☐ PT ☐ Unemployed ☐ Other_____

Employer_____ **Email**_____ **Type of Work**_____

Address _____ **Phone**_____

_____

Insurance Information:

☐ **Group** ☐ **Medicare** ☐ **Medical Assistance** ☐ **No Insurance (Cash)** ☐ **Health Savings Account**

Insurance Provider_____ **Member ID**_____

Group ID_____ **Phone**_____

Emergency Contact:

Name_____
Phone_____

Guarantor Info:

Name_____ **DOB**_____
Phone_____**Employer**_____

☐ **Option to Decline:** I have read and understand that if I choose not to provide any of the above information, my claim cannot be processed. I agree to be placed on a cash payment basis and my insurance will not be billed for my visit. Please sign below.

Signature_____ **Date**_____

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Date: / /

Health History:

Height_____ **Weight**_____

Major illnesses_____

Injuries/accidents_____

Major Surgeries_____

Additional Information_____

_____

_____

Chief Complaint:

Date Symptoms Began: _____/_____/_____

Complaint related to: ☐ **Workers Comp** ☐ **Auto Accident** ☐ **Chronic Discomfort**
☐ **Sports Injury** ☐ **Fall** ☐ **Home Injury** ☐ **Other**_____

Have you ever seen a chiropractor in the past? ☐ **Yes** ☐ **No** **Who?**_____

Have you reported to your employer, if work related? ☐ **Yes** ☐ **No**

Briefly describe your main complaint:

_____

_____

_____

Additional complaints:

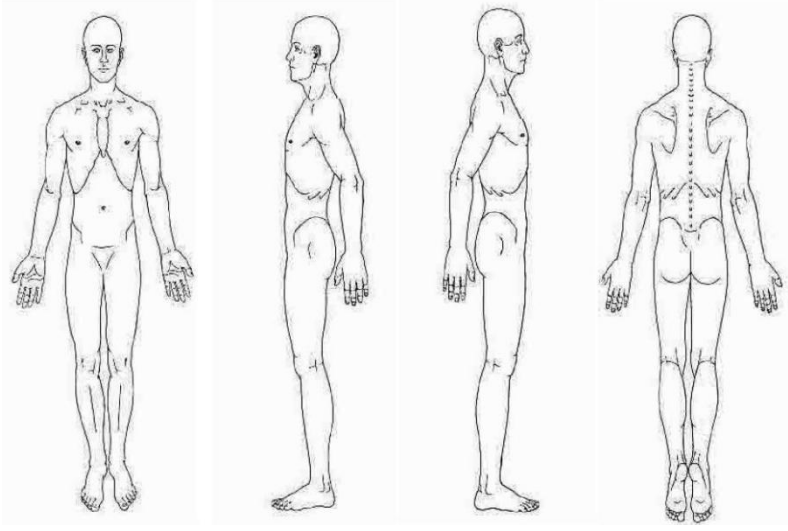
_____

_____

_____

Have you been treated by another chiropractor or physician for this problem? Who?

_____



In the diagram, circle area of complaint(s).
Describe type of pain by using symbols (below) in area of complaint:

T= tingling
S= stiff
A= achy
N= numbness
W= weak
G= stabbing
O= other