New Patient Intake Form

ESCOBAR CHIROPRACTIC

Name: _____ Date: _____

Cell Phone #: _____ Home Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____ E-Mail Address: _____

Age: _____ DOB: _____ ☐ Male ☐ Female

ACCIDENT INFORMATION: Date of Accident/Injury: _____ Where (Street/Intersection): _____

Were any tickets issued and to whom? _____

Were you the: ☐ Driver ☐ Front Seat Passenger (Right) ☐ Back Seat LEFT Passenger ☐ Back Seat RIGHT Passenger

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

Did the air bag deploy? ☐ Yes ☐ No Did you hit anything inside the vehicle? ☐ Yes ☐ No If yes, describe:

_____

Did you experience immediate pain? ☐ Yes ☐ No

Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No Did you drive to the hospital? ☐ yes ☐ No Which hospital? _____

Were x-rays taken? ☐ Yes ☐ No MRI? ☐ Yes ☐ No CT-scan? ☐ Yes ☐ No

Did they prescribe medication? ☐ Yes ☐ No

Are you taking new medication since the accident? ☐ Yes ☐ No Please List: _____

FIRST (MAJOR) COMPLAINT: _____

Date when symptoms first appeared: _____ Have you had this condition before? ☐ Yes ☐ No

What makes symptoms worse? _____ What makes symptoms better? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing

How much of your day are you in pain? ☐10% ☐25% ☐50% ☐100%

Severity of Pain: ☐ NONE ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 SEVERE

Does pain radiate into your: ☐ L ☐ R Shoulder/Arm/Hand ☐ L ☐ R Buttock/Leg/Foot ☐ N/A

SYMPTOMS: Please check if you have experienced any of the following since this accident.

☐ Low Back Pain	☐Tension Across Top of Shoulders	☐Pain between Shoulder Blades
☐ Numbness/Tingling in Arms/Hands	☐ Neck Pain	☐ Numbness/Tingling in Legs/Feet
☐ Difficulty talking	☐ Dizziness	☐ Tension/Headaches
☐ Pain in the legs/feet/buttocks	☐ Changes in Vision	☐ Pain in the hand/arm/shoulders
☐ Difficulty swallowing	☐ Difficulty with balance	☐ Tired/Fatigued
☐ Difficulty Sleeping	☐ Ringing in Ears	☐ Brain Fog
☐ Nausea	☐ Vomiting	☐ Other:

PREVIOUS ACCIDENT HISTORY: Have you ever been involved in another motor vehicle accident? ☐ Yes ☐ No

If yes, please describe and give dates: _____

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PATIENT INFORMATION

Occupation_____ Employer_____

Work Phone #: _____

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Separated ☐ Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3rs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Last Visit?

Have You Ever Received Physical Therapy? ☐ Yes ☐ No

Have You Ever Had An MRI? ☐ Yes ☐ No What Body Part? _____

INSURANCE

Do you have auto insurance? ☐Yes ☐ No Name of Carrier: _____

Do you have health insurance? ☐Yes ☐No Name of Carrier: _____

Do you have secondary insurance? ☐Yes ☐No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)
Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____
and | AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Escobar Chiropractic LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE (X) _____ **DATE** _____

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ESCOBAR CHIROPRACTIC

CURRENT SYMPTOMS

Are you currently under any medication and/or medical care?

☐ Yes ☐No If yes, explain_____

_____

Please list any and all medications you are currently taking:

_____

_____

Please list any surgeries and/or hospitalizations you have had (type & date):

_____

Please check to indicate any new symptoms since the accident/injury or symptoms made worse by the accident/injury:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs
☐ Arm/Hand Pain	☐ Light Bothers Eyes
☐ Leg/Knee Pain	☐ Recent Weigh Change
☐ Headaches	☐ Loss of Memory
☐ Night Pain	☐ Nausea
☐ Depression	☐ Loss of Taste
☐ Cold Extremities	☐ Fatigue
☐ Nervousness	☐ Chest Pain
☐ Sleeping Difficulties	☐ Tension
☐ Jaw Problems	☐ Fever
☐ Loss of Smell	☐ Cold Sweats
☐ Fainting	☐ Constipation/Diarrhea
☐ Dizziness	☐ Allergies
☐ Stomach Problems	☐ Shortness of Breath
☐ Asthma	☐ Blurred/Double Vision
☐ Swollen Joints	☐ Bowel/Bladder Changes
☐ Mood Changes	☐ Trouble Concentrating
☐ Foot Trouble	☐ Loss of Balance

Please check If you have ever had any of the following in the past:

☐ ADD/ADHD	☐ Herniated disc	☐ Heart Attack	☐ Aids/HIV	☐ Cataracts
☐ Heart Problems	☐ Alcoholism	☐ Hemorrhoids	☐ Allergy Shots	☐ Hepatitis
☐ Anemia	☐ Chicken Pox	☐ Anorexia	☐ Colon Trouble	☐ Cancer
☐ Appendicitis	☐ Contacts/Glasses	☐ Herpes	☐ Arthritis	☐ Diabetes
☐ High Cholesterol	☐ Asthma/Wheezing	☐ Hormone/Gland	☐ Dry Skin	
☐ Bad Breath/Bad	☐ Ear Infections	☐ Epilepsy	☐ Insomnia	☐ Mumps
☐ Liver Disease	☐ Kidney Problems	☐ Gall Bladder	☐ Fractures	☐ Breast Lump
☐ Menopausal Prob	☐ Broken Bones	☐ Gonorrhea	☐ Migraines	☐ Miscarriage
☐ Bulimia	☐ Heartburn	☐ Stroke	☐ Multiple Sclerosis	☐ Suicide Att
☐ Bleeding disorders	☐ Thvroid Problems	☐ TMJ Pain	☐ Osteoporosis	☐ Pacemaker
☐ Parkinson's Disease	☐ Tuberculosis	☐ Tumors/Growths	☐ Pneumonia	☐ Prostate Prob
☐ Vaginal Infections	☐ Prosthesis	☐ Venereal Disease	☐ Psychiatric	
☐ Rheumatoid Arthritis	☐ Rheumatic Fever	☐ Scarlet Fever		

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ALLERGIES: (Please list any known allergy that you have.)
☐ I HAVE NO KNOWN ALLERGIES ☐ sulfa Drugs ☐ NSAIDS

_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

Is there a family history of any of the following conditions? (Including parents, grandparents & siblings)

☐Heart Disease ☐Diabetes ☐Cancer ☐Arthritis ☐Other

Do you exercise: ☐ Frequently ☐Moderately ☐Occasionally ☐None

What is your daily/weekly intake of the following?

_____Caffeine cups/day Alcohol drinks/week_____ Cigarette's packs/day_____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam. I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct. I am not attempting to investigate Escobar Chiropractic, LLC as a representative of any agency or entity, or any insurance company or other organizational entity or person.

Name: _____ Signature: _____ Date _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

☐There is a possibility that I may be pregnant at this time.
☐Yes. I am definitely pregnant
☐No, I am not pregnant at this time
☐request that x-ray films not be taken because: _____ Date of last menstrual period: _____

Patient's Signature: _____

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