Date_____

FREMONT CHIROPRACTIC CLINIC
NEW PATIENT INTAKE FORM

File # _____

Contact information

Name_____ Referred By_____

Address_____ Employer_____

City_____ State____ Zip_____ Occupation_____

Phone (H)_____(C)_____ Work Phone _____

Cell Phone Provider_____ Marital Status M or S Spouse: _____

Date of Birth_____ Age_____ Social Security_____

Email_____

In Case of Emergency Contacts: (Please list 1 non-family member & 1 family member)

1. _____ 2. _____

Address_____ Address _____

Phone _____ Phone_____

Spouse and Children

Name_____ Age_____ Yes____ No____ Reason_____

Name_____ Age_____ Yes____ No____ Reason_____

Name_____ Age_____ Yes____ No____ Reason_____

Name_____ Age_____ Yes____ No____ Reason_____

Previous Chiropractic Care?

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through our examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply **Explain where applicable**

Birth (your birth)

Long Delivery?	Y N	_____
Difficult Delivery?	Y N	_____
Forceps?	Y N	_____
Caesarian?	Y N	_____
Breach/Cephalic?	Y N	_____
Home Birth?	Y N	_____
Epidural?	Y N	_____
Induced Labor?	Y N	_____

Growth and Development

Learn to care for your spine?	Y N	_____
Fall out of bed?	Y N	_____
Head trauma?	Y N	_____
Breastfeed?	Y N	_____
Fallen while learning to walk?	Y N	_____
Bullied by your siblings?	Y N	_____
Child abuse?	Y N	_____
Fallen down the stairs?	Y N	_____

Pulled by your arm? Y N _____
Chair pulled out when sitting? Y N _____

Current/Past Health Habits

Smoke? Y N _____
Drink alcohol or caffeine? Y N _____
Exercise Regularly? Y N _____
Do you eat healthy? Y N _____
Have you been in accidents? Y N _____
Have you had surgery? Y N _____
Drugs? (prescription or non) Y N _____
Have sleeping problems? Y N _____
Have occupational stress? Y N _____
Have mental stress? Y N _____
Have sports injuries? Y N _____
Sleep on stomach? Y N _____

Unwanted Health Condition/Reason for Your Visit Today

Chief Concern_____
Problem started on_____ **Onset due to:**_____
Pains are (please circle): Sharp Dull Shooting Tingling Burning Constant Intermittent
What activities aggravate your condition?_____
What activities lessen your condition?_____
Is the condition worse during certain times of the day?_____
Is the condition getting progressively worse?_____
Other doctors seen for this condition_____
Any home remedies?_____
Is this conditions interfering with; work?_____ **Sleep?**_____ **Routine?**_____ **Other?**_____
What medications are you taking right now?_____
Have you ever experienced this condition before? _____

Other Symptoms: (Please circle all that apply)

Headaches	**Neck Pain**	**Infertility**	**Sleeping Difficulty**
Anxiety	**Irritability**	**Chest pains**	**Dizziness**
Sinus Problems	**Numbness**	**Poor Immune Function**	**Depression**
Sensitivity to Light	**Ringing in Ears**	**Diarrhea**	**Constipation**
Cold hands/feet	**Upset Stomach**	**Heartburn**	**Irregular or Painful Menstruation**
Low Back Pain	**Sore throat**	**Joint Stiffness**	**Pain between shoulders**
Bladder Troubles	**Hemorrhoids**	**Gall Bladder Trouble**	**Pain in Extremities**
Jaw Pain	**Fatigue**	**Allergies**	**Other (Please Explain)**

Patient Signature_____ **Date**_____

Doctor Signature_____**Date**_____

Office Policies & Procedures

Fremont Chiropractic Clinic, PC

1.
2. **Daily Visit Procedure:** Each time you arrive for your visit have a seat in our reception area. The receptionist will direct you to a room. Please enter the room and lay face down on the adjustment table. When leaving the reception area, please bring your coats, children, and personal belongings with you. We will not be responsible for monitoring these things.
3. **Appointments**: A certain number of adjustments in a given time period is necessary to get the best results from your chiropractic care and create wellness in your life. While we cannot predict the exact number of adjustments you will need. We do know that consistency creates the best results. Therefore, it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule. We expect you to arrive on time so we can maintain our schedule; please call if you will be arriving late. If you are unable to keep your appointment, please, kindly, give us a 24 hour notice.
4. **Missed appointments:** If you do not keep a scheduled appointment and do not have the courtesy of giving us a 3 hour notice of canceling or rescheduling, we will charge a missed appointment fee of $30 per scheduled visit. We have a waiting list of patients that would be happy to fill those appointment slots.
5. **Progress Examinations:** During the course of your care you will receive several progress examinations to monitor your level of spinal correction. Plan on spending approximately 15 extra minutes in the office on these visits. The fee for this visit is $52.50. At your following visit the doctor will review the results with you.
6. **Exercise:** When you exercise in conjunction with your Chiropractic adjustments, you will find that your spine will improve more quickly. We recommend that you walk immediately after the adjustment for approximately 5-10 minutes. Additional exercise is also recommended on a daily basis. The doctor will tell you if you need to restrain from exercise at any time during your care.
7. **Nutrition:** Good nutrition is important to maximize your health and healing capability. A daily diet filled with 5-9 servings of fresh fruits and vegetables, lean protein, and whole grain is recommended. It is also very important that you are drinking 8-14 8-ounce glasses of water each day. If you have any questions about nutrition, please ask. We offer several nutritional products to supplement your diet.
8. **Results:** We are very result-orientated, however, many factors that we have no control over may affect how quickly you respond to your care. These include your age, occupation, lifestyle, diet, and stress levels, how long you have had your vertebral subluxation, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. During your healing process you will have good days and bad days. Our goal is to correct the cause of your problem, as well as your symptoms.
9. **Finances:** Health and accident insurance policies are an arrangement /agreement between an insurance carrier and yourself. You are personally responsible for payment for services rendered to you. Visit fees are due at the time of service. Account balances should not exceed $150.00.

Patient: _____ Date: _____

Congratulations on choosing Chiropractic!

You and your family will enjoy the health benefits that come with a Chiropractic lifestyle!