NEW PATIENT INTAKE FORM

Patient Information

Date: ______________________________________ DOB: ___________________________

Last Name: _______________________________ First Name: _________________________ MI: ___

Address: ____

City: _______________________________ State: ________ Zip: ________________

Home Phone: _________________________________ Cell Phone: _________________________________

E-mail: ____

Sex: □ M □ F Age: _____________

□ Married □Widowed □Single □Minor □ Separated □ Divorced

Occupation: _____________________________________ Patient Employer/School: ____________________________

Employer/School Address: ____

Spouse's Name: ____ # of Children: ________

Emergency Contact: _____________________________________ Phone #: ____________________________________

Relationship: _______________________________________

Insurance

Primary Account Holder: ___________________________ Relationship: _________________ DOB: _______________

Insurance Company: ____

Insurance ID #: _________________________________ Group #: ____

Secondary Insurance: □ YES (if yes please list below) □ NO

Insurance Company: ____

Insurance ID #: _________________________________ Group #: ____

PATIENT CONDITION

Reason for Visit: ____

When did your symptoms appear? ____

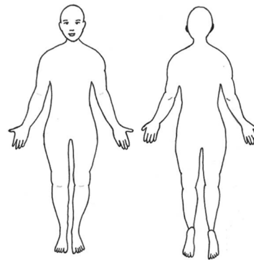
Were you hospitalized for this condition? □ YES □ NO

Have you received treatment for this condition? □ YES □ NO

If yes, what type of treatment? □ Medication □ Surgery □ Physical Therapy

□ Chiropractic Care □ Other __________________________

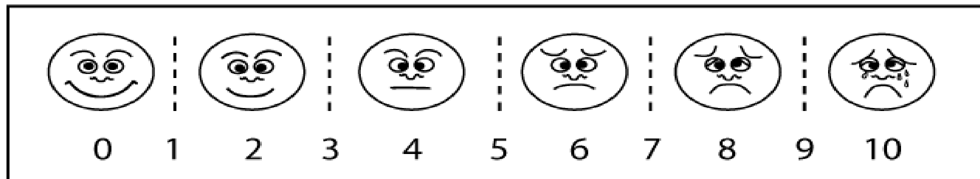
Please mark an X on the picture where you have pain:



Notes:
____
____
____
____
____

Is this condition getting progressively worse? □ YES □ NO □UNKNOWN

Rate the severity of your pain on a scale from 0 (least pain) to 10 (severe pain):



Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other ________

Does your pain radiate? □ YES Where? ______________________ □ NO

How often do you have this pain? □ 0%-25% □ 25%-50% □ 50%-75% □ 75%-100%

Does your pain interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Complaint Aggravated by: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

□ Temperature Changes □ Twisting □ Other ____________________________

Complaint Relieved by: □ Ice □ Heat □ Lying Down □ Prescribed Medication □ Stretching

□ Rest □ Increased Activity □ OTC Medication □ Other ___________________

Health History

Please check all that apply:

MUSCULO-SKELETAL SYSTEM
__ Neck Problems
__ Arm Problems
__ Pain between shoulders
__ Low back problems
__ Leg Problems
__ Swollen joints
__ Painful joints
__ Stiff joints
__ Sore muscles
__ Weak muscles
__ Walking problems
__ Ruptures of tendons
__ Broken bones

GENITO-URINARY SYSTEM
__ Bladder trouble
__ Excessive urine
__ Scanty urine
__ Painful urination
__ Discolored urine

GASTRO-INTESTINAL SYSTEM
__ Poor appetite
__ Excessive hunger
__ Difficulty chewing
__ Nausea
__ Vomiting food
__ Vomiting blood
__ Abdominal pain
__ Diarrhea
__ Constipation
__ Black stool
__ Hemorrhoids
__ Liver trouble
__ Gall bladder problems
__ Weight gain/loss

NERVOUS SYSTEM
__ Numbness
__ Paralysis
__ Dizziness
__ Fainting
__ Headaches
__ Muscle jerking
__ Convulsions
__ Forgetfulness
__ Confusion
__ Depression

CARDIO-VASCULAR SYSTEM
__ Chest pain
__ Rapid heart beat
__ Hight blood pressure
__ Low blood pressure
__ Heart problems
__ Varicose veins

RESPIRATORY SYSTEM
__ Difficulty breathing
__ Persistent cough
__ Coughing up blood
__ Coughing up phlegm
__ Lung problems

PRIOR CONDITIONS
__ AIDS/HIV
__ Anemia
__ Appendicitis
__ Arthritis
__ Ashtma
__ Bronchitis
__ Cancer
__ Diabetes
__ Hepatitis
__ Hernia
__ Herniated disc
__ Osteoporosis
__ Parkinson's
__ Pacemaker
__ Rheumatoid
__ Stroke
__ Tuberculosis
__ Tumors
Other _______________
____
____

Exercise	Work Activity	Habits	
□ None	□ Sitting	□ Smoking	Packs/Day ___________
□ Light	□ Standing	□ Alcohol	Drinks/Week _________
□ Moderate	□ Light Labor	□ Caffeine Drinks	Cups/Day ____________
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____________

Are you Pregnant? □ Yes □ No Due Date: ______________________

Injuries/Hospitalizations/Surgeries/X-rays you have had:

Car Accidents________________________________ Date: _______________
Head Injuries ________________________________ Date: _______________
Broken Bones ________________________________ Date: _______________
Hospitalizations ______________________________ Date: _______________
Surgeries ___________________________________ Date: _______________
X-rays _____________________________________ Date: _______________

Medications	Allergies	Vitamins/Supplements
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

The questions/diagrams and other information on this 3-page form have been answered completely and truthfully to the best of my knowledge. I understand that withholding medical information may compromise the ability of the treating doctor to diagnose and treat my condition.

Signature ____________________________________ Date: _______________________

Acknowledgement of Receipt – Notice of Privacy Practices

I, __________________________, hereby acknowledge Cullen Chiropractic & Wellness, LLC has provided me with a copy of its Privacy Practices that describes how health care information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Cullen Chiropractic & Wellness, LLC
472 Boston Post Road
Orange, Connecticut, 06477
(203) 799-7100

I understand I am entitled to receive updates upon request if and when Cullen Chiropractic & Wellness, LLC amends or changes its Privacy Practices in a material way.

Privacy Policy

The Department of Health and Human Services established a "Privacy Rule" to help insure that personal information is protected for your privacy. This rule was also created in order to provide a standard for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know we respect the privacy of your personal healthcare information (PHI). We strive to take reasonable precautions to protect your privacy. When appropriate, we provide the necessary information to only those we believe are in need of your health care information. We also support your full access to your personal health care records.

We may have relationships with facilities that only interact with doctors and are not required to obtain patient consent. You may refuse to consent to our disclosing your PHI to any such facilities. Under the law, Cullen Chiropractic & Wellness, LLC has the right to refuse to treat you should you choose not to disclose your PHI.

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature ___________________________________ Date ___________________