

# QUEENSBURY FAMILY CHIROPRACTIC

## NEW PATIENT INTAKE FORM

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### PATIENT INFORMATION

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Social Security # \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ # Children \_\_\_\_\_

Status: Minor\_\_\_ Married\_\_\_ Single\_\_\_ Divorced\_\_\_ Widowed\_\_\_

Phone: (Home) \_\_\_\_\_

(Work) \_\_\_\_\_

(Cell) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Phone & Address \_\_\_\_\_

**Emergency Name:** \_\_\_\_\_

**Contact** Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Whom may we thank for referring you?**

( \_\_\_\_\_ )

### INSURANCE

Who is responsible for this account (who's name is on the insurance card)? \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_

Group # \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Is patient covered by additional insurance? \_\_\_ Yes \_\_\_ No

2<sup>nd</sup> Insurance Company \_\_\_\_\_

Group # /Id # \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

\_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. Bruce P. Steinberg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

***Please present your card(s) to the office manager for processing!***

### PATIENT CONDITION

Is there more than one area of complaint? \_\_\_ Yes \_\_\_ No

Is the main complaint due to an accident(Auto or work-related)? \_\_\_ Yes \_\_\_ No

When did the complaint start? \_\_\_\_\_

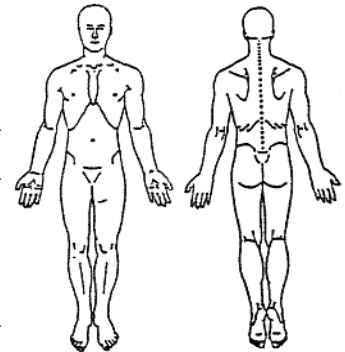
What caused the problem? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_ Worse? \_\_\_\_\_

Have you experienced this problem before Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

What type of pain are you feeling? (ex. sharp, dull, aching, throbbing, etc.) \_\_\_\_\_

Does the pain radiate (travel)? \_\_\_\_\_ Where? \_\_\_\_\_



Rate the pain from 0 (no pain) to 10 (most pain)    0   1   2   3   4   5   6   7   8   9   10

How often do you experience symptoms ? <25% of the time/day    25%-50% of the time/day    50%-75% of the time/day    >75% of the time/day

What activities of daily living are affected (circle all that apply)?    Sitting    Standing    Walking    Bending    Lying Down    Sexual Activity

Putting on/Taking off clothing    Working    Sleeping    Going from Sitting to Standing    Running/ Exercising    Daily activities    Driving/Riding in Car

Specific Hobbies Affected: \_\_\_\_\_

# HEALTH HISTORY

What treatment have you tried for this condition? \_\_\_\_\_

Have you ever been to a Chiropractor before? \_\_\_\_\_ Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Name and clinic of other doctor(s) who have treated you for this condition \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Blood test \_\_\_\_\_ Urine test \_\_\_\_\_

**Circle "Yes" or "No" to indicate if you have had any of the following:**

AIDS/HIV	YES	NO	Chicken Pox	YES	NO	Liver Disease	YES	NO	Rheumatoid Arthritis	YES	NO
Alcoholism	YES	NO	Diabetes	YES	NO	Measles	YES	NO	Rheumatic Fever	YES	NO
Allergy Shots	YES	NO	Emphysema	YES	NO	Migraine Headache	YES	NO	Scarlet Fever	YES	NO
Anemia	YES	NO	Epilepsy	YES	NO	Miscarriage	YES	NO	Stroke	YES	NO
Anorexia	YES	NO	Fracture	YES	NO	Mononucleosis	YES	NO	Suicide attempt	YES	NO
Appendicitis	YES	NO	Glaucoma	YES	NO	Multiple Sclerosis	YES	NO	Thyroid Problems	YES	NO
Arthritis	YES	NO	Goiter	YES	NO	Mumps	YES	NO	Tonsillitis	YES	NO
Asthma	YES	NO	Gonorrhea	YES	NO	Osteoporosis	YES	NO	Tuberculosis	YES	NO
Bleeding Disorder	YES	NO	Gout	YES	NO	Pacemaker	YES	NO	Tumors, Growths	YES	NO
Breast Lump	YES	NO	Heart Disease	YES	NO	Parkinson's Disease	YES	NO	Typhoid Fever	YES	NO
Bronchitis	YES	NO	Hepatitis	YES	NO	Pinched Nerve	YES	NO	Ulcers	YES	NO
Bulimia	YES	NO	Hernia	YES	NO	Pneumonia	YES	NO	Vaginal Infections	YES	NO
Cancer	YES	NO	Herniated Disc	YES	NO	Polio	YES	NO	Venereal Disease	YES	NO
Cataracts	YES	NO	Herpes	YES	NO	Prostate Problems	YES	NO	Whooping Cough	YES	NO
Chemical Dependency	YES	NO	High Cholesterol	YES	NO	Prosthesis	YES	NO	Other _____		
			Kidney Disease	YES	NO	Psychiatric Help	YES	NO	Other _____		

Do you smoke? YES NO \_\_\_\_\_ Packs per day      Do you exercise? YES NO      How often? \_\_\_\_\_

Do you use alcohol? YES NO \_\_\_\_\_ Drinks per week      Rate your stress level 0 1 2 3 4 5 6 7 8 9 10

Caffeine? YES NO \_\_\_\_\_ Drinks per week      Do you sleep well? YES NO      Hours of sleep / night \_\_\_\_\_

Are you pregnant? YES NO      Due Date: \_\_\_\_\_

**Which best describes your present health goals:**  pain relief only     correct entire problem     wellness/ preventative care

**Injuries / Surgeries (please indicate year)**

**Description**

Falls \_\_\_\_\_

Head injury \_\_\_\_\_

Broken bones \_\_\_\_\_

Surgeries \_\_\_\_\_

**Medications / Diagnosis**

**Allergies**

**Vitamins / Herbs**

_____ _____ _____	_____ _____ _____	_____ _____ _____
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