New Patient Intake Form

Cornerstone Chiropractic Clinic - 13470 N. 83rd Ave, Ste 302 - Peoria, AZ 85381 - 623.249.7141-Dr. Jessica J. Haug DC, CCSP

General Information

Name:_____SSN:_____ Date:_____ File #_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Email Address: _____ May we contact you via email? _____
Age: _____ Date of Birth: ____/____/_____ Marital Status: M S W D
Occupation:_____ Employer:_____
Work Phone: (_____) _____ - _____
Spouse's Name: _____ Phone: (_____) _____ - _____
Name of Nearest Relative: _____ Phone: (_____) _____ - _____
Names & Ages of Children (if applicable):

_____

Family Medical Doctor:

_____

How were you referred to our office?

_____

Insurance Information

I have health insurance that covers chiropractic care. ___Yes ___No. If yes, please allow us to make a copy of it.
I do not have health insurance that covers chiropractic care, and opt to pay cash. ___Yes ___No
I am interested in a discounted cash plan for wellness care? ___Yes ___No
I am interested in a family wellness plan? ___Yes ___No
Is your current condition a result of an accident/injury? ___Yes ___No If yes: __Auto __Work __Slip/Fall

History of Present Illness

Purpose of this appointment (wellness or specific concern)_____
Explain:_____

_____

_____

When did you first notice the problem?

_____

How did it originally occur?_____
How has it progressed recently? (circle) Same/Improving/Getting Worse
How frequent is the condition? (circle) Constant/Frequently/Intermittent/Occasionally
Describe the pain: (circle all that apply) Sharp/Dull/Numbness/Tingling/Aching/Burning/Stabbing/Throbbing or Other:_____
Does anything relieve the problem? If so, please list. ___No ___Yes

_____

What does this problem prevent you from doing or enjoying?

_____

Past Medical History

Pleas check any of the following conditions that you have been diagnosed with or experienced.

___Broken or Fractured Bones	___Osteoarthritis	___Eating Disorders	___Diabetes
___Circulatory Problems	___Epilepsy	___Alcoholism	___Glaucoma
___Rheumatoid Arthritis	___Pace Maker	___Drug Addiction	___Dizziness
___Seizures/Convulsions	___Strokes	___HIV Positive	___Osteoporosis
___Any Congenital Diseases	___Gall Bladder Problems	___Cancer	___Metal Screws
___Excessive Bleeding	___Ruptures	___Depression	___Ringing in the Ears
___High/Low Blood Pressure	___Coughing Blood	___Ulcers	

Please list any major illnesses, injuries, falls, auto accidents, or surgeries (including dates). Women include information regarding childbirth.

_____

_____

_____

_____

_____

Have you been treated, for any health condition, by a physician within the last year? ____No ____Yes
If yes, please list:

_____

_____

_____

Are you taking any supplements? ____No ____Yes
If Yes, Please List:

_____

_____

_____

Women: Is there any chance you may be pregnant? ____Yes ____No ____Not Sure
Please list any additional health problems you have, no matter how insignificant they may be.

_____

_____

_____

Social History

Please check the following that apply to your lifestyle. (Please describe frequency and type)

____Alcohol_____

____Tobacco Products_____

____Caffeine_____

____Exercise_____

____Hobbies_____

_

What percentage of the day are you: ___% Lifting ___% Sitting ___% Bending ___% Working at a computer?

Family History

Please check any conditions that run in your family and indicate whether the family member is your **G**randparent, **F**ather, **M**other, **S**ister or **B**rother.

____Diabetes	____Cancer	____Mental Illness	____Arthritis
____Stroke	____Asthma	____Kidney Disease	____Liver Disease
____Heart Disease	____Lung Disease	____Other:_____	

ANY other pertinent information that the doctor should be aware of: ____No ____Yes
If yes, please describe_____

_____

☐ initials I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES FOR MEDICAL AND SUPPLEMENTAL SERVICES, INCLUDING THOSE THAT ARE NOT COVERED BY MY INSURANCE PLAN.

☐ initials FAILING TO SHOW FOR A SCHEDULED APPOINTMENT, WITHOUT NOTICE, WILL RESULT IN A FULL EXAMINATION CHARGE OF $60.

_____ _____

PATIENT (OR GUARDIAN) SIGNATURE DATE