NEW PATIENT INTAKE

1 PATIENT INFORMATION

Date ______

Social Security # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

City ______ State ______ Zip ______

Sex ☐ Male ☐ Female Age ______

Height ______ Weight ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Child

☐ Separated ☐ Divorced ☐ Partnered

E-mail ______

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (   ) ______

Spouse's Name ______

Birthdate ______

Social Security # ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE INFORMATION

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-name Insurance Company(ies) and assign directly to ProAdjuster Chiropractic of South Jersey LLC / Dr. Gregory Bader, DC 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.

______
Signature of Patient, Guardian or Personal Representative

______
Please print name of Patient, Guardian or Personal Representative

______ ______
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (   ) ______ Home Phone (   ) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______ Relationship ______

Home Phone (   ) ______ Work Phone (   ) ______

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes. Date ______ ☐ No

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______

5 PATIENT HEALTH HISTORY

Primary Doctor Name ______ Phone Number (   ) ______ Date of Last Physical Exam ______

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ______

Name and address of other doctor(s) who have treated you for your condition ______

______

	Date of Last	Anything Abnormal?		Date of Last	Anything Abnormal?
Blood Test	______	______	Urine Test	______	______
Chest X-Ray	______	______	Spinal X-Ray	______	______
Spinal Exam	______	______	MRI, CT-Scan, Bone Scan	______	______

HEALTH HISTORY - CONTINUED

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Lung Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Reproductive Disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Eye Issues	☐ Yes	☐ No	Menstrual Cramps	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Bladder Issues	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Suicide Attempts	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No
Chemical/Alcohol Dependency	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
			Herpes	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Concussion	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Irritable Bowel (IBS)	☐ Yes	☐ No	Poor Circulation	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No			

CANCER ☐ Yes ☐ No Type ______________________

OTHER MEDICAL CONDITIONS ______________________

☐ I certify that I have disclosed my complete medical history, and I deny any other medical conditions. **Please initial here** __________

EXERCISE
☐ None ☐ Daily
☐ Moderate ☐ Heavy

WORK ACTIVITY
☐ Sitting ☐ Standing
☐ Light Labor ☐ Heavy Labor

HABITS
☐ Smoking ______ Packs/Day ☐ Coffee/Caffeine ______ Cups/Day
☐ Alcohol ______ Drinks/Week Stress Level ☐High ☐Mod ☐Low

Are you pregnant? ☐ Yes ☐ No
Due Date __________
____ # of Miscarriages

Name of Child & DOB	Type of Delivery	Complications

Injuries/Surgeries you have had			Please Describe	Date
Falls	☐ Yes	☐ No		
Head Injuries	☐ Yes	☐ No		
Broken Bones/Fractures	☐ Yes	☐ No		
Dislocations	☐ Yes	☐ No		
Surgeries/Fusions	☐ Yes	☐ No		

6 MEDICATIONS

Medication	Reason
	Reason
	Reason
	Reason
	Reason

SUPPLEMENTS

____
____
____
____

7 ALLERGIES / SENSITIVITIES

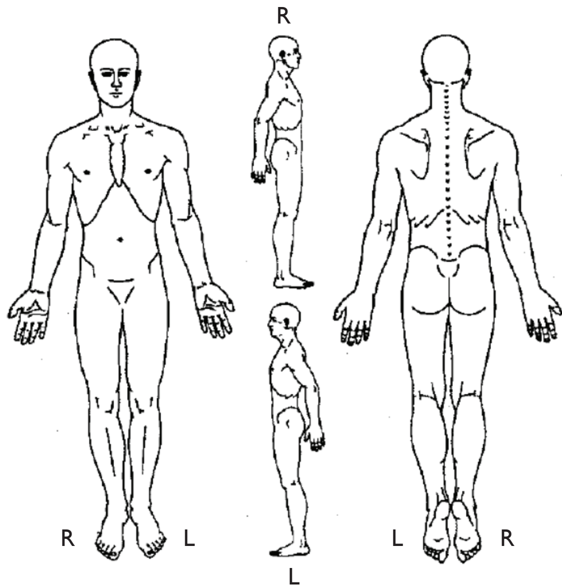
Food ☐ Dairy ☐ Wheat ☐ Corn ☐ Soy ☐ Gluten ☐ Peanuts ☐ Fruits ☐ Other ______________

Medications ☐ Penicillin ☐ Sulfa Drugs ☐ Iodine ☐ Insulin ☐ Antibodics ☐ Other ______________

Seasonal ☐ Pollen ☐ Dust ☐ Hay ☐ Mold ☐ Chemical(s) ☐ Smoke ☐ Animals ☐ Insects

Other ______________________

PATIENT CONDITION



Reason for visit ______________________________
____
____
____

When did your symptoms appear? ______________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Symptoms have persisted for # ____ Hour(s) ____ Day(s) ____ Week(s) ____ Month(s) ____ Year(s)

Mark an X on the picture above where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ___________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______________________________

Is it constant or does it come and go? ______________________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Other ______________________________

What activities or hobbies would you like to get back to once you begin to feel better? ______________________________
____

ADDITIONAL SYMPTOMS

Please check any additional symptoms you may be experiencing:

- ☐ Blurred Vision
- ☐ Cold Feet
- ☐ Cold Hands
- ☐ Cold Sweats
- ☐ Concentration Loss
- ☐ Confusion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Head seems too heavy
- ☐ Headaches
- ☐ Increased Irritability
- ☐ Insomnia
- ☐ Light bothers eyes
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Low Back Pain
- ☐ Low Energy
- ☐ Low resistance to colds
- ☐ Muscle Jerking
- ☐ Neck Pain
- ☐ Numbness in Fingers / Toes
- ☐ Pain in Joints
- ☐ Poor Digestion
- ☐ Pins & Needles in Arms / Legs
- ☐ Shoulder Pain
- ☐ Shortness of Breath
- ☐ Skin Issues
- ☐ Stiff Neck
- ☐ Stomach Upset