

# Laguna Bay Chiropractic

## New Patient Intake Form

Please Fill This Form Out Completely

DATE: \_\_\_\_\_

### Patient Data:

Title: Mr. Mrs. Ms. Miss (Circle One)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell/Home/Work (circle one)

Date Of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone Number for Emergency Contact: \_\_\_\_\_

Occupation: \_\_\_\_\_

Who can we thank for referring you into the office today?

### What Is Bothering You Today?

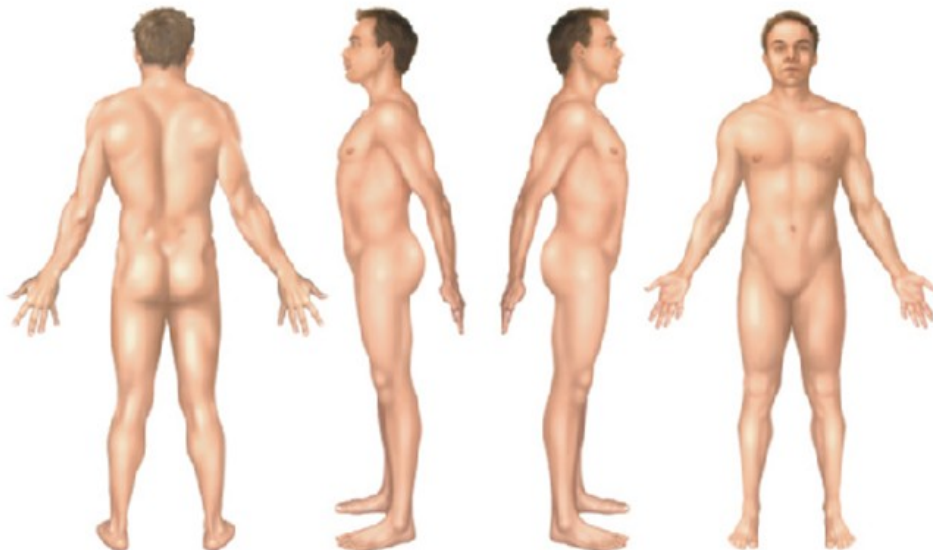
Brief description:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Indicate The Location Of You Pain Below:

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness    B = Burning    S= Stabbing    P = Pins & Needles    A = Dull Ache



Pain Level: Circle One (BEST) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

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**Describe your pain:** (circle all that apply) Sharp Dull Achy Stabbing Numb  
Tingling Shooting Burning Radiating Getting Worse Getting Better

**Frequency of your pain:** (circle one)

Constant (76-100% of the day)

Frequent (51-75% of the day)

Occasional (26-50% of the day)

Intermittently (0-25% of the day)

**Date of injury?** \_\_\_\_\_

**Cause of injury?** \_\_\_\_\_

**Have you had this problem before?** Yes/No (circle one) When: \_\_\_\_\_

**Have you seen another doctor for this condition?** Yes/No (circle one)

**Name of other doctor:** \_\_\_\_\_

**Primary care doctor:** \_\_\_\_\_

**What makes it feel better?:** \_\_\_\_\_

**What makes it feel worse?:** \_\_\_\_\_

**Describe your personal health history including any medications you are taking, any allergies and any surgeries or traumas you have had:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe your family health history including causes of deaths, diseases and medical conditions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_

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### **Laguna Bay Chiropractic Office Policies:**

#### **Payment Information:**

Payments for services are expected at the time services are rendered unless payment arrangements have been made with the office manager in advance. If you have any questions regarding payments and fees in our office please ask our billing manager.

#### **Privacy Policy:**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and service we provide you. This information is kept private and is not shared with anyone without a release of information form signed and on file by you. If you would like us to be able to share your information with someone, including your spouse, please let us know.

#### **Benefits, Risks and Alternatives:**

I understand that, as with all forms of manual therapy, there are certain benefits, risks and alternatives to receiving chiropractic care. I accept these benefits, risks and alternatives and understand that if I have concerns or questions regarding the benefits, risks and alternatives of Chiropractic Manipulative Therapy I have the right to discuss them with the doctor and refuse care.

**I have read and understand the above information.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_