# North Shore Chiropractic

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Please Print and fill out our Patient Intake Form, Please use blue or black ink and print clearly.

## *Patient Information:*

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ❑ Female ❑ Male **Birthdate:** _____ **Height**:_____ **Weight** _____

Home Phone: (____)_____ Cell Phone: (____)_____ **E-mail:** _____

Do you prefer to receive calls at: ❑Home ❑ Work ❑ Cell ❑ No Preference

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

## *Patient Condition/Symptoms:*

**Reason for visit**: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? ❑Yes ❑No

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down ❑Other

Does the pain interfere with your- ❑Work ❑Sleep ❑Daily Routine ❑Recreation

***Type of pain**: ❑Sharp ❑ Dull ❑Throbbing ❑ Numbness ❑Aching ❑ Shooting

❑Burning ❑Tingling ❑Cramps ❑ Stiffness ❑Swelling ❑ Other _____

***Circle the severity of your pain 1 thru 10**. (1 = mild pain or discomfort, to 10 = excruciating pain)

**1 2 3 4 5 6 7 8 9 10**

Is the pain present what % of the awake time? ❑ (0-25%) ❑ (26-49%) ❑ (50-75%) ❑ (76-90%) ❑ (100%)

What treatment have you received for your condition?

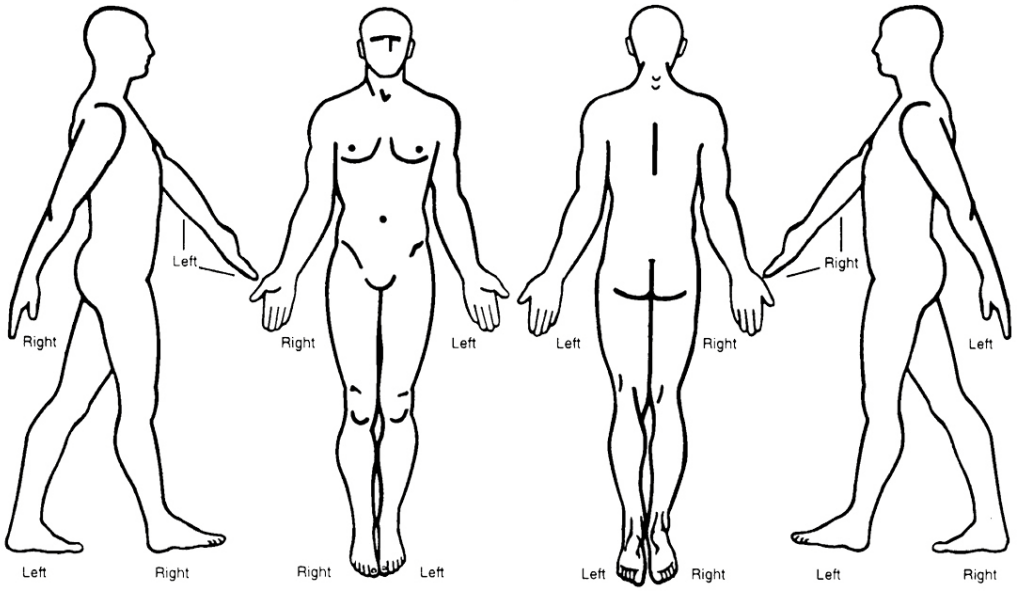
❑Medication ❑Surgery ❑Physical Therapy ❑Chiropractic ❑ Other _____

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

_____

Please indicate on the figures below, <u>your areas of pain and label the type of pain</u>

(eg. aching, burning, spasm)




# *Health History*

*Check only those conditions which are applicable:*_____

- ❑ Anemia
- ❑ Arthritis
- ❑ Bone Weakness
- ❑ Cancer
- ❑ Concussions
- ❑ Elbow Pain
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Herniated disk
- ❑ Irritable Bowl Disease
- ❑ Knee Pain
- ❑ Low Back Pain
- ❑ Migraine Headaches
- ❑ Neurological Disorder
- ❑ Pinched Nerve
- ❑ Rheumatoid Arthritis
- ❑ Sleep Apnea
- ❑ Stroke (Heart or Brain)
- ❑ Ulcers
- ❑ Ankle Pain
- ❑ Asthma
- ❑ Breast Lump
- ❑ Chest Pain
- ❑ Depression
- ❑ Emphysema
- ❑ Fatigue
- ❑ Gluten Sensitivity
- ❑ Hearing Problems
- ❑ High Blood Pressure
- ❑ Jaw Pain
- ❑ Leaky Gut Syndrome
- ❑ Lyme′ s Disease
- ❑ Minor Heart Trouble
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Shingles
- ❑ Spinal Cord Injury
- ❑ Thyroid Problems
- ❑ Ulcerative Colitis
- ❑ Appendicitis
- ❑ Autoimmune Disease
- ❑ Broken Bones
- ❑ Congestive Heart Failure
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Foot Pain
- ❑ Gout
- ❑ Heart (Mitral Valve)
- ❑ High cholesterol
- ❑ Joint Stiffness
- ❑ Leg Pain
- ❑ Menstrual Problems
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Polio
- ❑ Shoulder Pain
- ❑ Sprain/Strain Injuries
- ❑ Tuberculosis
- ❑ Wrist Pain
- ❑ Arm Pain
- ❑ Back Pain
- ❑ Bronchitis
- ❑ Chicken Pox
- ❑ Dizziness
- ❑ Eye/Vision Problems
- ❑ Genetic Spinal Disorder
- ❑ Hand Pain
- ❑ Hepatitis
- ❑ Hip Pain
- ❑ Kidney disease
- ❑ Liver Disease
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Parkinsons Disease
- ❑ Prostate Problems
- ❑ Significant Weight Change
- ❑ Stomach Problems
- ❑ Tumor (s)
- ❑ No Problems Reported

**History Continued:**

Dates of last exams:_____

(Woman) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

Do you have breast implants? ❑ Yes ❑ No Surgical Prosthesis? ❑ Yes ❑ No

List any types of injuries or surgeries which you have had and the dates which they occurred:

_____

_____

***Please list all medications you are currently taking**: _____

Is your present condition due to an accident? ❑Yes ❑ No ( If Yes, please ask for the Personal Injury Forms)

If Yes – Type of Accident ❑ Auto ❑ Work ❑ Home ❑ Other Date of Accident: _____

***Allergies(prescriptions or foods)**: _____

## *Daily Habits:*

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____

Nutritional supplements (if any)? _____

***Do you smoke?** ❑ **Yes** ❑ **No** How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily?_____

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports ❑Custom Orthotics

Are you dieting: ❑ No ❑ Yes Since ____/____/____

### *FINANCIAL ARRANGEMENTS:*

**Payment is required at the time the treatment is rendered.** Fee schedule is based on face-to-face time with Dr. Gregory Smith DC in 20-minute increments. A standard initial intermediate office visit (40 to 50 minutes) is $85.00 to $105.00 and subsequent intermediate office visits (20 minutes) are $65.00, this fee schedule is subject to additional charges incurred in the performance of additional procedures for a specific treatment time 10 minutes at $40 and 20 minutes at $65. Personal Injury and other complex issues require a more complete (60 minute) physical exam and treatment that are billed accordingly. Cash payments are required for all nutritional supplements received. If you are covered by insurance for chiropractic care, we will assist you with billing your insurance. This service is provided as an office courtesy, and we do not guarantee payment by insurance companies. Medicare **does not** cover your Initial Exam Visit.

**You are responsible financially for services rendered.**

## *Certification and Assignment:*

To the best of my knowledge, the above information is complete and correct. I have read, understand and agree to the policy of this office. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

**Print Name** **Signature** **Date**