East Plano Chiropractic & Wellness
2200 Los Rios Blvd #127
Plano, Tx 75074

New Patient Intake Form

Patient Data

Name_____ Date_____ Email*_____

*Email will not be shared and will only be used for occasional office announcements and appointment reminders

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Wireless Carrier_____Home Phone_____ Work Phone_____

Sex □ M □ F Birth Date_____ Age_____ Social Security Number_____

□ Single □ Married □ Widowed □ Separated □ Divorced Number of Children_____

Ethnicity_____ Native Language_____ Occupation_____ Employer_____

Spouse's Name_____ Spouse's Occupation_____ Spouse's Employer_____

Emergency Contact_____ Phone _____

How did you hear about this clinic?_____ Name of person who referred you_____

Current Complaints

Nature of the Injury: □ Automobile □ Work □ Other

Please Describe _____

_____

What caused the problem? _____

Date of injury_____ Date symptoms appeared_____

Did your pain come on: □ Suddenly □ Gradually Is the pain: □ Mild □ Moderate □ Severe

Do you experience pain every day? □ Yes □ No

Do your symptoms interfere with daily life? □ Yes □ No

Does the pain wake you up at night? □ Yes □ No

Are your symptoms worse at certain times of the day? □ Yes □ No

Do changes in weather affect your symptoms? □ Yes □ No

Do you wear orthotics? □ Yes □ No

Do you take vitamins or supplements? □ Yes □ No

Which activities aggravate your symptoms _____

Have you ever had this same condition before? □ Yes □ No If yes, when?_____

List other practitioners seen for this condition_____

Payment Information

Name of party responsible for payment_____ Phone _____

Do you have health insurance? □ Yes □ No Name of insurance company _____

***If auto accident, please provide:**

Insurance company name _____ Contact Person _____

Phone_____ Claim Number _____

Patient Signature _____Doctor Signature_____

Medical History

Have you been treated for any conditions in the last year? □ Yes □ No
If yes, please describe_____

Date of last physical exam_____ Is there a chance that you are pregnant? □ Yes □ No

What medications are you taking and for what conditions? Please list dosage and amounts:
_____
_____

What Vitamins minerals or herbs do you currently take? Please list for what conditions, dosage and frequency_____
_____
Are you allergic to any medications?
_____
_____

Family History: (Circle all that apply)
Arthritis: Parent Sibling
Cancer: Parent Sibling
Diabetes: Parent Sibling
Heart Disease: Parent Sibling
Hypertension: Parent Sibling
Stroke: Parent Sibling
Thyroid: Parent Sibling
Other _____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of chiropractic care and other treatment techniques to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsi-ble for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. Understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

_____ _____
Patient Name (Print) (Parent or Guardian if under 18) Date

_____ _____
Patient Signature (Parent or Guardian if under 18) Date