

New Patient Intake

Please complete all sections prior to your first visit.

Full name

Date of birth

Address

Gender

Phone

Best Email

Occupation

How did you hear about us?

Guardian name (if patient is under age 18)

Relationship to patient

Phone

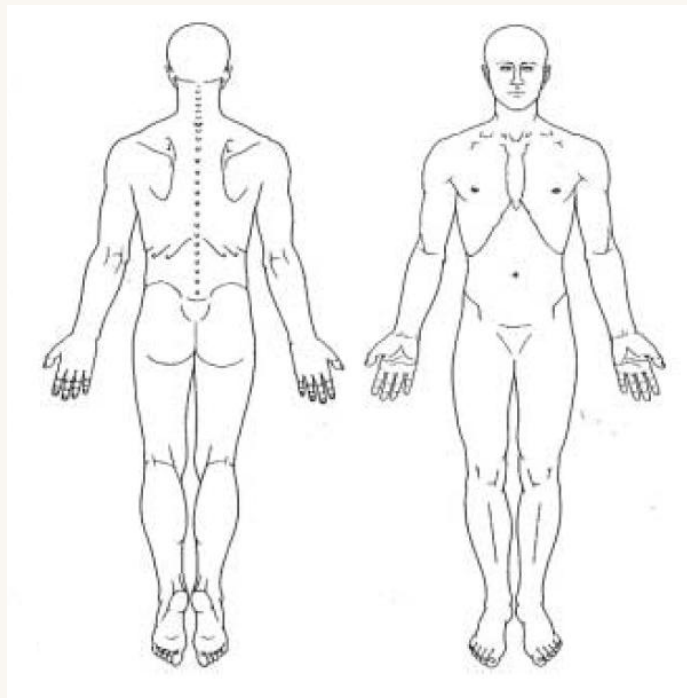
EMERGENCY CONTACT

Name

Relationship

Phone

Mark all areas of pain below with an X.



CHIEF COMPLAINT

What is the reason for today's visit? _____

When did this incident begin? _____

Have you experienced this pain or injury before? If so, please elaborate. _____

Was your pain completely resolved at that time? _____

Please rate your pain **today** on the pain index below.

0 = No pain at all

10 = Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

Please select one number for your pain at its best and one number for your pain at its worst. (Select 2 numbers.)

0 1 2 3 4 5 6 7 8 9 10

Have you seen anyone else for this pain? _____

What have you tried to make the pain better? _____

What aggravates the pain? _____

Is there a time of day the pain worsens? If so, when? _____

Do you experience your pain constantly or does it come and go?

Constant

Intermittent (comes and goes)

Please describe the quality of your pain.

Dull

Achy

Throbbing

Stabbing

Shooting

Sharp

Electrical

Are you experiencing pain anywhere else and/or does the pain travel anywhere? If so, where? _____

MEDICAL HISTORY

Have you been diagnosed with any illnesses or conditions? If so, please list them here.

Are you currently being treated for these conditions? If so, which ones? _____

Please list out all of the medications you are currently taking and the reason(s) for each.

Have you ever undergone surgery? If so, what and when? _____

Have you ever been hospitalized? If so, why and when?

Do you have a history of broken bones? If so, please list with the year(s) of the injury.

Do you have any known allergies? (to medications, foods, environment, latex, etc.) _____

LIFESTYLE

What is your occupation? _____

How many hours a day do you sit? _____

How many hours a day do you stand? _____

Do you smoke? If so, how many a day? _____

Do you drink alcohol? If so, how much a week? _____

Do you take recreational drugs? If so, how often? _____

Is there anything else you would like to share with me?

Review of Systems

Please check any symptoms you currently have or have experienced recently.

GENERAL

Fever	Chills
Fatigue	Night sweats
Weight gain	Weight loss
Weakness	

CARDIOVASCULAR

Chest pain	Palpitations
Rapid heartbeat	Swelling of legs
High blood pressure	Poor circulation

EYES

Blurred vision	Double vision
Eye pain	Red eyes
Dry eyes	Vision loss

RESPIRATORY

Shortness of breath	Wheezing
Chronic cough	Coughing blood
Sleep apnea	Snoring

EARS / NOSE / THROAT

Hearing loss	Ringing in ears (tinnitus)
Ear pain	Dizziness
Sinus congestion	Nosebleeds
Sore throat	Difficulty swallowing
Hoarseness	

GASTROINTESTINAL

Heartburn	Nausea
Vomiting	Constipation
Diarrhea	Abdominal pain
Blood in stool	Bloating

GENITOURINARY

Frequent urination	Painful urination
Blood in urine	Urinary urgency
Urinary incontinence	Kidney stones

Review of Systems

Please check any symptoms you currently have or have experienced recently. (continued)

MUSCULOSKELETAL

Neck pain	Mid-back pain
Low back pain	Joint pain
Joint stiffness	Muscle pain
Muscle weakness	Arthritis
Difficulty walking	

NEUROLOGICAL

Headaches	Migraines
Dizziness	Vertigo
Numbness	Tingling
Tremors	Seizures
Memory problems	Loss of balance

SKIN

Rash	Itching
Hives	Dry skin
Easy bruising	Skin lesions
Hair loss	

HEMATOLOGIC / LYMPHATIC

Easy bleeding	Easy bruising
Swollen lymph nodes	History of anemia

ENDOCRINE

Heat intolerance	Cold intolerance
Excessive thirst	Excessive urination
Excessive hunger	Thyroid problems

ALLERGIC / IMMUNOLOGIC

Seasonal allergies	Food allergies
Medication allergies	Frequent infections
Autoimmune disease	

PSYCHIATRIC

Anxiety	Depression
Mood changes	Difficulty sleeping
Panic attacks	Memory concerns

I have reviewed this intake form and confirm that the information provided is accurate and complete to the best of my knowledge. I agree to notify Bloom Family Chiropractic of any changes to my medical history or personal information.

Patient Signature (electronic signature accepted): _____

Date: _____

HIPAA Acknowledgment

Notice of Privacy Practices — please read before signing.

YOUR PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act (HIPAA), you have the right to privacy regarding your protected health information (PHI). This includes your right to review your records, request corrections, ask us to limit how your information is shared, and receive a copy of our full Notice of Privacy Practices, which is available at our office upon request.

HOW WE USE YOUR INFORMATION

We may use and disclose your health information to provide your treatment, to bill for services and collect payment, and to carry out the everyday operations of our practice. We will not use or share your information for any other purpose without your written authorization, except where required by law.

OUR COMMITMENT TO YOU

We are required by law to maintain the privacy of your health information, provide you with this notice of our legal duties and privacy practices, and abide by the terms currently in effect. If we make a material change to our privacy practices, an updated notice will be made available to you.

ACKNOWLEDGMENT

Signing below does not mean you are agreeing to any special use or sharing of your health records — only that you have received, or had the opportunity to receive, a copy of our Notice of Privacy Practices.

I acknowledge receipt of, or the opportunity to receive, this Notice of Privacy Practices.

SIGNATURE

Patient (or guardian) signature (electronic signature accepted)

Date

HOW TO SUBMIT

Once completed, please email this form to BloomFamilyChiropractic@proton.me with your name in the subject line.