# 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

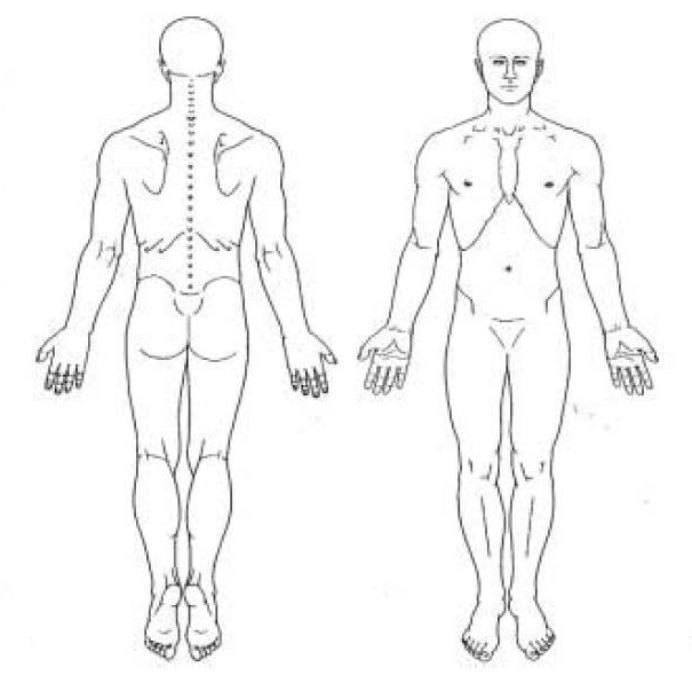
## EMERGENCY CONTACT

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

## ALLERGIC / IMMUNOLOGIC

- Seasonal allergies
- Food allergies
- Medication allergies
- Frequent infections
- Autoimmune disease

## ENDOCRINE

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

## 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 BloomChiropractic@pm.me with your name in the subject line.