Belding Chiropractic Center
New Patient Intake Form

Name: _____
Date of Birth: __/__/_____ Today's Date:__/__/_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell/Home/Work
Email: _____ Occupation:_____
Insurance Company: _____
Insurance Policy #:_____ Name of Insured: _____
Marital Status: Married / Single Insured's Date of Birth: _____
Primary Care Physician's Name: _____

Reason for seeking care:
_____
_____

Is your problem due to a work injury or auto accident? Yes / No
Have you been treated by a chiropractor in the past? Yes / No

- If yes, was it for the same problem? Yes / No
- If yes, when were you last treated? _____

Have you tried other treatments for this problem? Yes / No

- **If yes, what have you tried?** Surgery/Injections/Medication/Physical **Therapy/Massage/Other**
    - If other, please explain:
      _____
    - Please list any surgeries and approximate dates:
        - _____
        - _____
        - _____
        - _____

Do you smoke? Yes / No

- If yes, how much per day? _____

Do you drink alcohol? Yes / No

- If yes, how many drinks per week? _____

Do you take any medications, supplements or vitamins? Yes / No

- If yes, please list them:
    - _____
    - _____
    - _____
    - _____
    - _____
    - _____
    - _____
    - _____

How did you hear about Belding Chiropractic Center? _____

Do you have any food or drug allergies? Yes / No

- If yes, please list them:

_____

Do you have any previous diagnosed conditions? Yes / No

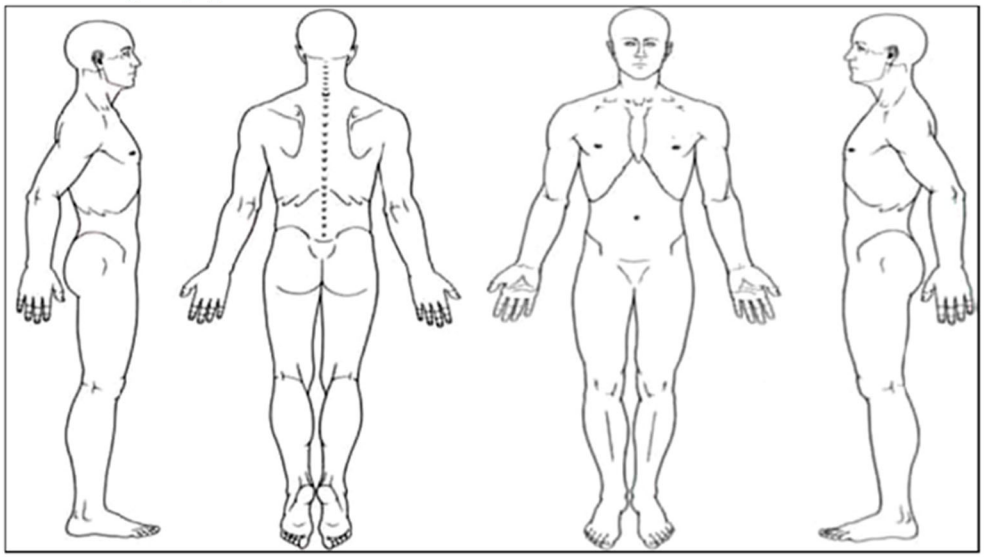
- If yes, please list them:

_____

Please list any known conditions in your immediate family.

_____

Please mark where you are feeling pain with an X.
For numbness/tingling/pins and needles, use horizontal lines (=).



Is this pain due to an injury? Yes/No
If yes, please describe: _____
Approximately when did the pain begin? _____
On a scale of 1-10, where 10 is the worst pain you have ever felt and 0 is no pain, how would you rate your pain? _____/10
How would you describe the pain?
Sharp Dull Burning Stabbing Aching Throbbing Shooting
Other: _____
Does anything make the pain better? _____
Does anything make the pain worse? _____
Does the pain radiate into other areas of your body, such as the arms, legs, or chest?
Yes/No If yes, please describe: _____
Are your experiencing numbness, weakness, or bowel/bladder problems?
Yes/No If yes, please describe: _____
Is your pain worse at any particular time of day?
Yes/No If yes, please describe: _____
Additional Notes:
_____
_____
_____

Belding Chiropractic Center
Review of Systems
Please check any symptoms you are currently having.

Constitutional
□ Weight Loss
□ Fatigue
□ Fever

Eyes
□ Eye Pain
□ Double Vision
□ Cataracts

Ear, Nose, Throat
□ Difficulty Hearing
□ Ringing in the Ears
□ Vertigo
□ Sinus Trouble
□ Nasal Stuffiness
□ Frequent Sore Throat

Cardiovascular
□ Heart Murmur
□ Chest Pain
□ Palpitations
□ Dizziness
□ Fainting
□ Shortness of Breath
□ Difficulty Lying Flat
□ Swelling Ankles

Endocrine
□ Loss of Hair
□ Heat/Cold Intolerance

Respiratory
□ Cough
□ Coughing Blood
□ Wheezing
□ Chills

Gastrointestinal
□ Heartburn/Reflux
□ Nausea/Vomiting
□ Constipation
□ Change in Bowel Movement
□ Diarrhea
□ Jaundice
□ Abdominal Pain
□ Black or Bloody Stool

Genitourinary
□ Burning
□ Frequency
□ Nighttime
□ Blood in Urine
□ Discharge
□ Bladder Leakage

Allergic/Immune
□ Hives
□ Eczema
□ Hay Fever

Psychiatric
□ Anxiety/Depression
□ Mood Swings
□ Difficulty Sleeping

Hematologic/Lymphatic
□ Easy Bruising
□ Gums Bleed Easily
□ Enlarged Glands

Musculoskeletal
□ Joint Pain/Swelling
□ Stiffness
□ Muscle Pain
□ Back Pain
□ Neck Pain
□ Arm/Shoulder/Hand Pain
□ Leg/Hip/Foot Pain

Skin
□ Rash/Sores
□ Lesions
□ Itching/Burning
□ Suspicious Moles

Neurological
□ Loss of Strength
□ Numbness
□ Headaches
□ Tremors
□ Memory Loss

Belding Chiropractic Center
215 E State St. Belding, MI 48809
Workers Compensation & Auto/Personal Injury:

Have you filed an injury report with your employer? Y / N
If yes:
Date: ___/___/_____ Time: _____am/pm
Carrier: _____ Policy # _____
Carrier Phone: (_____)_____-_____ Adjuster:_____
Claim #: _____

Patient Name (print): _____ Patient Signature: _____
Date: _____
Guardian or Spouse's Signature of Authorizing Care (if patient is a minor): _____
Date: _____

Authorization Agreement (MEDICARE PATIENTS ONLY)

I, _____ Medicare Number _____, request that payment of authorized Medicare benefits be made either to me or on my behalf to Belding Chiropractic Center for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature: _____ Date: _____

Consent for purpose of treatment, payment, and healthcare operations
(All Patients)

Patient Acknowledgement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Belding Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the chiropractic clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate through the use of chiropractic treatment, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office.

By subscribing my name below, I also acknowledge that I have received the chiropractic clinic's notice of privacy practices for protected health information, and my understanding and my agreement to its terms.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____