

NEW PATIENT INTAKE

Address City State Zip Seasonal Address City State Zip Make Gemale	Name	Date_		SS#				
Seasonal Address								
General Gene		•			-			
Birthdate								
Spouse or Parent's Name								
Spouse or Parent's Name								
Spouse or Parent's Name								
Emergency Contact	-	•						
Who may we thank for referring you to us? Did you see our Web Site?Yellow Page Ad?Other? Name of local primary PhysicianCityMay we contact them? □Yes □No YOUR HEALTH SUMMARY Please check all symptoms you have ever had, even if they do not seem related to your current problem. □ Headaches □ Pins and Needles in legs □ Fainting □ Neek Pain □ Loss of Shallee □ Dizziness □ Buzzing in ears □ Ringing in ears □ Stomach upset □ Eatigue □ Depression □ Irritability □ Tension □ Steeping problems □ Neek stiff □ Cold hands □ Cold feet □ Diarrhea □ Constipation □ Fever □ Hot flashes □ Cold sweats □ Lights bother eyes □ Problem urinating □ Hearthurn □ Menstrual Pain □ Menstrual Tegularity □ Ulcers Women - How many children? □ Pregnant? □ Date of last Menstrual Cycle Nursing? □ Taking Birth Control Pills? □ Previous Surgeries and Dates? List ALL Medications you are currently taking □ Drink per week? *All above questions have been answered accurately; I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to this office. *I give Pain Free Move Well Clinic and its representative's permission to communicate to me via the contact information above. *This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.	1							
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Headaches								
Pins and Needles Loss of smell Back Pain Loss of balance Dizziness Buzziness Buzzing in ears Ringing in ears Nervousness Numbness in fingers Numbness in toes So f taste Stomach upset Fatigue Depression Irritability Tension Cold feet Diarrhea Constipation Fever Hot flashes Cold sweats Lights bother eyes Problem urinating Heartburn Mood swings Menstrual Pain Menstrual irregularity Ulcers								
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Women - How many children? Pregnant? Date of last Menstrual Cycle Nursing? Taking Birth Control Pills? Previous Surgeries and Dates? List ALL Medications you are currently taking What kind of exercise do you do? What supplements do you take? How much do you smoke per day? Drink per week? *All above questions have been answered accurately; I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to this office. *I give Pain Free Move Well Clinic and its representative's permission to communicate to me via the contact information above. *This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.		□ Constination		□ Fever				
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Nursing?Taking Birth Control Pills? Previous Surgeries and Dates? List ALL Medications you are currently taking What kind of exercise do you do? What supplements do you take? How much do you smoke per day? Drink per week? *All above questions have been answered accurately; I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to this office. *I give Pain Free Move Well Clinic and its representative's permission to communicate to me via the contact information above. *This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.	□ Mood swings	□ Menstrual Pair	n	□ Menstru	al irregularity	□ Ulcers		
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Guardian Signature Date	Patient Signature				Date			
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