Pain Free Move Well Clinic
Chiropractic • Massage • Rehab

NEW PATIENT INTAKE

Name_____ Date_____ SS# _____
Address_____City_____ State_____ Zip_____
Seasonal Address_____City_____ State_____ Zip _____
❑Male ❑Female ❑_____ ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated
Birthdate_____ Home Phone_____ Cell _____
Work Phone_____ E-mail Address _____
Occupation_____ #years _____
Spouse or Parent's Name_____ Phone _____
Emergency Contact_____ Phone _____ Relation _____
Who may we thank for referring you to us? _____
Did you see our Web Site?____ Yellow Page Ad? ____ Other? _____
Name of local primary Physician_____City_____ May 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
- □ Dizziness
- □ Numbness in fingers
- □ Fatigue
- □ Sleeping problems
- □ Diarrhea
- □ Cold sweats
- □ Mood swings
- □ Pins and Needles in legs
- □ Loss of smell
- □ Buzzing in ears
- □ Numbness in toes
- □ Depression
- □ Neck stiff
- □ Constipation
- □ Lights bother eyes
- □ Menstrual Pain
- □ Fainting
- □ Back Pain
- □ Ringing in ears
- □ Loss of taste
- □ Irritability
- □ Cold hands
- □ Fever
- □ Problem urinating
- □ Menstrual irregularity
- □ Neck Pain
- □ Loss of balance
- □ Nervousness
- □ Stomach upset
- □ Tension
- □ Cold feet
- □ Hot flashes
- □ Heartburn
- □ 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_____
_____
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.**

Patient Signature_____ Date_____

Guardian Signature_____Date_____