LAKE CITY CHIROPRACTIC AND MASSAGE CENTER

1. First Name: _____ Middle Name: _____ Last Name: _____ Preferred Name: _____

DOB: _____ SSN: _____

PATIENT INTAKE

Welcome to our practice. We're so happy to meet you! Please fill out the patient intake form completely. If a question does not apply to you, simply skip to the next question. The information you fill in will be given directly to our staff, which will speed up your office visit and allow us to better serve your healthcare needs. Thank you!

ABOUT YOU

2. Home Address

Physical Adress: _____ City _____

State _____ Zip Code _____

Mailing Adress if not the same: _____ City _____

State _____ Zip Code: _____

3. Contact Information

Mobile Phone: _____ Home Phone: _____ Day Phone: _____

Preferred Phone: _____ Primary Email Address _____

Preferred Contact/Appointment Reminder Method:
☐ Phone Call Reminder(s) ☐ Text Reminder(s) ☐ Email Reminder(s)

4. Demographic Information

Sex at birth:
☐ Male ☐ Female

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact Name: _____ Contact Phone Number: _____ Relationship to Patient: _____

5. Employment Information

Employment Status:
- ☐ Employed ☐ Retired ☐ Student ☐ Homemaker
- ☐ Permanently fully/partially disabled
- ☐ Unemployed

Place of Employment (If Applicable)

_____

6. Insurance/Primary Care Provider Information

Primary Care Provider Name: _____

Provider Phone Number: _____

Provider Address:

_____

Insurance Information (If Applicable)

Primary Insurance Name: _____

Member ID: _____

Group Number: _____

Secondary Insurance Name: _____

Member ID: _____

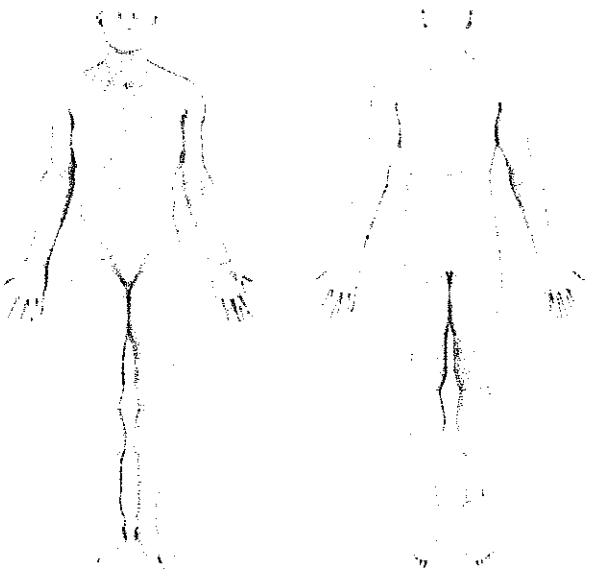
Group Number: _____

VISIT PURPOSE

7. Select the main reason for this visit:

- ☐ Pain
- ☐ Maintenance/Wellness Visit
- ☐ Personal Injury
- ☐ Motor Vehicle Accident
- ☐ Worker's Comp Injury

8. AREAS OF CONCERN (please circle all that apply)



9. **On a scale from 0-10 (10 being the worst pain possible), how would you rate your pain today in office?**

○ 0/10 ○ 1/10 ○ 2/10 ○ 3/10 ○ 4/10 ○ 5/10 ○ 6/10 ○ 7/10 ○ 8/10 ○ 9/10 ○ 10/10

10. **On a scale from 0-10 (10 being the worst pain possible), how would you rate your pain at worst?**

○ 0/10 ○ 1/10 ○ 2/10 ○ 3/10 ○ 4/10 ○ 5/10 ○ 6/10 ○ 7/10 ○ 8/10 ○ 9/10 ○ 10/10

11. **Date your problem began:**

_____

12. **How did your problem begin?**

_____

_____

_____

_____

13. **Describe your pain:**

○ Dull Ache	○ Tightness	○ Throbbing
○ Sharp	○ Stabbing	○ Burning
○ Numbness	○ TIngling	○ No pain

14. **How often do you experience pain?**

○ Constantly/Daily	○ Frequently	○ Randomly
○ Morning	○ Evening	

15. **Does your pain radiate/move to other parts of your body?**

○ Yes ○ No ○ Not Sure

16. **Please Describe Where Your Pain Radiates:**

_____

_____

_____

_____

17. **What have you done to relieve the symptoms? (ex: ice, heat, massage, acupuncture, chiropractic, medication, stretching/exercising, etc.)**

_____

_____

_____

_____

18. What makes your pain better?

19. What makes your pain worse?

CURRENT HEALTH

20. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		
4		
5		

21. Please list Surgical history if applicable (include name & date of surgery)

22. Other than the condition(s) already shared, do you have any additional health concerns? (Please Specify by Circling or Writing in the Blank Space Provided)

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

PERSONAL AND FAMILY HISTORY

23. Previous Medical History & Family Medical History

	Yes	No
Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		
Have you ever received Chiropractic treatment?		

24. Explanation Box:

If you have answered yes to any of the above, please share this info with your doctor.

SOCIAL HABITS

25. Personal social habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

26. Present exercise habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

27. Anything Else You Would Like Your Doctor To Know?

Lake City Chiropractic & Massage Center
Dr. Kevin B. Harrison, D.C.

1680 SW Newland Way, Suite 105 – Lake City, Florida 32025
Office: (386) 752-3877 Fax: (386) 752-3544

DATE: _____ **SSN:** _____

NAME: _____ **DOB:** _____

If the patient is a minor, we ask that his/her parent or legal guardian sign on behalf of the patient. Thank you!

AUTHORIZATION TO TREAT

I, _____, hereby consent to treatment from Dr. Harrison and whomever he may designate as his assistant to administer Chiropractic care as he deems necessary.

ASSIGNMENT OF PAYMENT-ATTORNEY (IF MVA/LIABILITY)

I, _____, hereby authorize and request my attorney to make payment directly to Dr. Harrison, and monies due to him may be deducted from any settlement made on my behalf.

RELEASE OF MEDICAL RECORDS

I, _____, hereby request the release of medical records (x-rays, office notes, reports, etc.) that may be deemed necessary for my treatment with Lake City Chiropractic to release any medical information to my insurance company, attorney, or anyone else that he deems necessary for my treatment.

ASSIGNMENT OF PAYMENT-INSURANCE COMPANY

I, _____, hereby give authorization of benefits to be made directly to Lake City Chiropractic. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all cost of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as original.

Appointment Agreement

I, _____(Print Name)
understand that my appointment, chiropractic and/or massage therapy, is valuable to Dr. Harrison and the Lake City Chiropractic & Massage Center staff. Therefore, I agree that I am responsible for any fees or consequences that may be subjected to me if I miss my appointment, or do not cancel my appointment at least 24 hours prior to my scheduled appointment time.

Failure to cooperate with office polices may result in office dismissal.

_____ _____

(Please Sign) (Date)