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ADULT NEW PATIENT INTAKE FORM

Patient Name (First, Middle initial and Last) _____

DOB: _____ Sex: ☐ M ☐ F SSN: _____ - _____ - _____

Street Address: _____ City, State, Zip: _____

Cell Phone: _____ Email Address: _____

Marital Status: ☐ M ☐ S ☐ W ☐ D How did you hear about us? _____

Employment Status: ☐ Employed ☐ Student Occupation: _____

Emergency Contact Name and Relation: _____

Emergency Contact Phone Number: _____

Current Health Condition:

Chief Complaint (Why are you here today?): _____Date of Onset: _____

Have you seen any other physician for this condition? If yes, who? _____

Since onset, has anything helped you? If yes, what? _____

Are you currently taking any prescription medications? Please list. _____

Are you currently taking any supplements? Please list. _____

Are you currently under Chiropractic Care? ☐ YES ☐ NO If yes, who is your DC? _____

Please list any allergies (drug, non-drug, sensitivities, etc.): _____

How would you describe your diet? ☐ POOR ☐ ADEQUATE ☐ GOOD ☐ EXCELLENT

Please list any dietary restrictions. _____

How would you describe your sleep quality? ☐ POOR ☐ ADEQUATE ☐ GOOD ☐ EXCELLENT

How many hours each night, typically? _____

How much screen time are you exposed to each day? ☐ MILD ☐ MODERATE ☐ EXCESSIVE

How often do you exercise? ☐ NEVER ☐ QUIT ☐ DAILY ☐ WEEKLY ☐ MONTHLY

How often do you use tobacco? ☐ NEVER ☐ QUIT ☐ DAILY ☐ WEEKLY ☐ MONTHLY

How often do you drink alcohol? ☐ NEVER ☐ QUIT ☐ DAILY ☐ WEEKLY ☐ MONTHLY

How often do you use illicit drugs? ☐ NEVER ☐ QUIT ☐ DAILY ☐ WEEKLY ☐ MONTHLY

How would you describe your daily stress levels? ☐ NONE ☐ MILD ☐ MODERATE ☐ EXCESSIVE

Complete Health History:

EYE/VISION- ☐ **NONE**	**BLINDNESS, WEAR GLASSES OR CONTACTS, CATARACTS, ITCHING, GLAUCOMA, TEARING**
NERVOUS SYSTEM- ☐ **NONE**	**DIZZINESS, MEMORY LOSS, LOSS OF CONSCIOUSNESS, NUMBNESS, SLEEP DISTURBANCE, STROKES, WEAKNESS, SEIZURES, HEADACHES, TREMORS**
EAR, NOSE AND THROAT- ☐ **NONE**	**BLEEDING, SNORING, SMELL LOSS, TASTE LOSS, SORE THROAT, SINUS OR EAR INFECTIONS, CONGESTION, TINNITUS, DIFFICULTY SWALLOWING**
CARDIOVASCULAR- ☐ **NONE**	**CHEST PAIN, HEART MURMUR, ORTHOPNEA (DIFFICULTY BREATHING LYING DOWN), SWELLING OF LEGS, ULCERS, VARICOSE VEINS, PALPITATIONS**
RESPIRATION- ☐ **NONE**	**ASTHMA, COUGHING UP BLOOD, COUGH, WHEEZING, SPUTUM PRODUCTION, SHORTNESS OF BREATH**
GASTROINTESTINAL- ☐ **NONE**	**ABDOMINAL PAIN, DIARRHEA, HEARTBURN, JAUNDICE, INDIGESTION, CONSTIPATION, RECTAL BLEEDING, ABNORMAL STOOL, HEMORRHOIDS, VOMITING**
ENDOCRINE- ☐ **NONE**	**COLD OR HEAT INTOLERANCE, EXCESSIVE APPETITE, DIABETES, EXCESSIVE THIRST OR HUNGER, HAIR LOSS, VOICE CHANGES, GOITER**
SKIN- ☐ **NONE**	**CHANGES IN NAIL TEXTURE OR SKIN COLOR, HIVES, ITCHING, RASH, SKIN LESION/ ULCER, NUMBNESS, TINGLING, PRICKLING**
PSYCHOLOGICAL- ☐ **NONE**	**ANHODENIA, MOOD CHANGES, MEMORY LOSS, ANXIETY, BIPOLAR DISORDER, CONVULSIONS, CONFUSION, DEPRESSION, INSOMNIA**
ALLERGY- ☐ **NONE**	**ANAPHYLAXIS, ITCHING, FOOD INTOLERANCE, SNEEZING, NASAL CONGESTION**
HEMATOLOGY- ☐ **NONE**	**ANEMIA, BLOOD CLOTTING, BRUISES EASILY, BLEEDING, BLOOD TRANSFUSION(S), FATIGUE, LYMPH NODE SWELLING**
FEMALE- ☐ **NONE**	**BIRTH CONTROL, BREAST LUMP, CRAMPS, VAGINAL DISCHARGE, BURNING URINATION, HORMONE THERAPY, IRREGULAR MENSTRUATION**
MALE- ☐ **NONE**	**BURNING URINATION, ERECTILE DYSFUNCTION, IRREGULAR URINATION, HESITANCE/DRIBBLING, PROSTATE PROBLEMS**

Please list any previous injuries. _____

Have you ever had any surgeries or procedures? Please list. _____

For Women: Have you ever been pregnant? If yes, how many times? _____

Any additional comments: _____

_____

_____

Please circle all that apply.

Childhood Illnesses: ☐ I deny any childhood illness(es) Other: _____

☐ ADD ☐ ADHD ☐ Allergies ☐ Anemia ☐ Asthma ☐ Bed-wetting

☐ Cerebral Palsy ☐ Chicken Pox ☐ Diabetes ☐ Ear Infections ☐ Eczema ☐ Headaches

☐ Measles ☐ Mumps

Adult Illnesses: ☐ I deny any adulthood illness(es) Other: _____

☐ Alzheimer's ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Crohn's ☐ CRPS

☐ Depression ☐ Diabetes ☐ Emphysema ☐ Lung Disease ☐ Lupus ☐ M.S. ☐ Kidney Disease ☐ Parkinson's ☐ Pneumonia ☐ Scoliosis ☐ Shingles ☐ STD/STI ☐ Thyroid Issues

Immunizations: ☐ I deny any immunizations ☐ Diphtheria, Tetanus and Pertussis ☐ TB ☐ Chicken Pox

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Influenza ☐ Polio ☐ Measles, Mumps & Rubella

☐ Pneumococcal ☐ Small Pox ☐ Whooping Cough ☐ COVID-19

Family Health History

FAMILY HISTORY	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	CHILD
CANCER							
HEART							
DIABETES							
KIDNEY							
AUTOIMMUNE							
HEREDITARY							
PSYCHIATRIC							
OTHER							

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Patient Name: _____ Signature: _____Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

I **do / do not (please circle one)** give consent to ATC/ATIH to use my/my families pictures or testimony for the purpose of advertising.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow- up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose and carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date: _____

ATIH Staff Name: _____ Signature: _____ Date: _____

Written Consent for a Child, AGE 18 AND YOUNGER

Name of patient who is a minor/child _____

I authorize Sylvia Zakusilov, RN MSN NP-C and any and all Amberwood Terrace Integrated Health staff to perform diagnostic procedures, radiographic evaluations, renders care and perform treatment to my minor/child.

As of this date, I have the legal right to select and authorize healthcare services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Amberwood Terrace Integrated Health.

Guardian Signature _____ Date:_____

ATIH Staff Signature: _____Date: _____