Chiropractic Sports Medicine
Fort Wayne

Patient Intake

Insurance

Co. Name: _____
Address: _____
CITY STATE ZIP
Phone #: _____
Insured's ID#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Date of Birth: ___/___/___
Insured's Employer: _____
Please inform front desk of 2nd. Insurance source.

About You

Today's Date: ___/___/___ File #: _____
Patient Name: _____
LAST FIRST MI
What You Prefer To Be Called: _____ ❑ Male ❑ Female
Birthdate: ___/___/___ Age: _____ SS#: _____
Mailing Address: _____
CITY STATE ZIP
Home Phone #: _____
Work Phone #: _____ Ext: _____
Other Phone #s: _____
E-mail Address: _____
Referred By: _____
Employer: _____ How Long? _____
Employer's Address: _____
CITY STATE ZIP
Occupation: _____
Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Spouse's Name: _____
Do you have children? ❑ Yes ❑ No How many? _____

Emergency Contact

Who should we contact? _____
Relation: _____
Home Phone #: _____
Work Phone #: _____
Who is your Medical Doctor? _____
M.D.'s Phone #: _____

Health History

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For women: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

Minor Consent

I hereby authorize Dustin Sherman, DC to administer Chiropractic care as is deemed necessary to:

(Minor): _____

Relationship to minor: _____

Signed (Parent/Guardian): _____

Print Name: _____

Reason for Visit

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

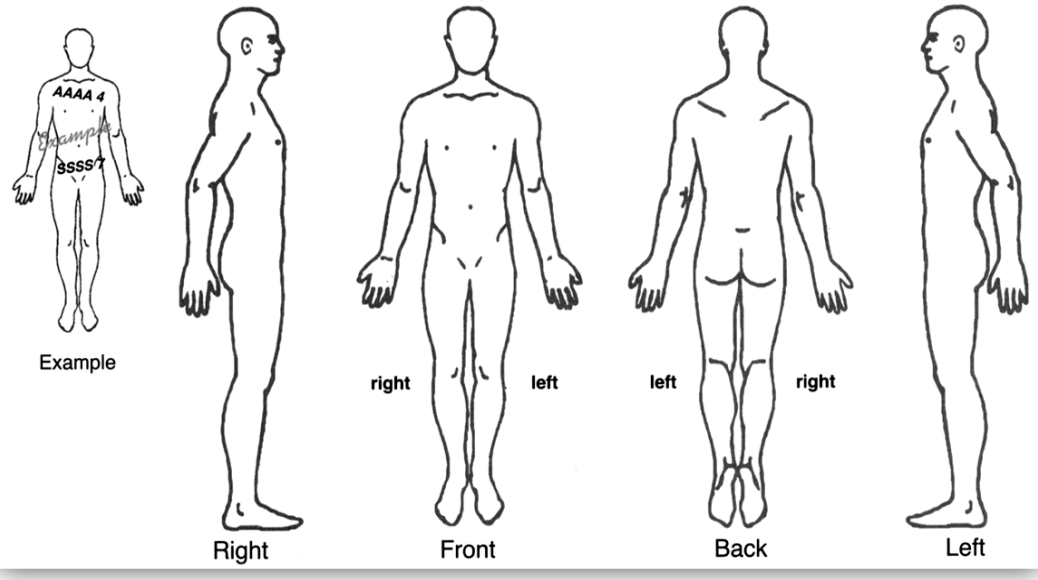
If so, whom? _____ Phone#: _____

Pain Diagram

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



Pain scale

Circle which best describes you pain.

No pain
1
2
3
4
5
6
7
8
9
10
Worst pain

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse