NEW PATIENT INTAKE

Health & Human Performance
20300 Ventura Blvd. Suite 245 Woodland Hills, CA 91364

Demographics

Name:_____
Date of Birth:_____/_____/_____ Age:_____ Gender:_____
Address:_____
City:_____ State:_____ Zip:_____
Primary Phone:_____ Type of phone: Home Work Mobile
Secondary Phone:_____ Type of phone: Home Work Mobile
Email:_____ Social Security Number:_____
Marital Status: Single Married Divorced Widowed Name of Spouse:_____
Your Occupation:_____ Your Employer:_____
How did you hear about our office? Yelp Facebook
Referred by_____ Other_____
Emergency Contact Name:_____
Emergency Contact Number:_____ Relation:_____

Chiropractic Experience

Have you ever been to a chiropractor? Yes No (If No, skip to the next section)
Date of Care: _____to_____ Reason for Care: Injury/Pain Relief Wellness/Lifestyle
What were the results? _____

Insurance Information

Do you have PPO health insurance? _____Yes _____No (**we are NOT HMO providers**)

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Relationship to Patient:	Relationship to Patient:
Policy ID Number:	Policy ID Number:
Group Number:	Group Number:
Please have your insurance card and driver's license ready to be copied for your medical records	

History of Condition(s) and/or Concern(s)

Please identify the condition(s)/concern(s) that brought you to the office in order of importance:
First:_____ Second:_____
Third:_____ Fourth:_____
On a scale of **1 to 10** with 10 being the worst pain, rate your above condition(s)/concern(s) by circling
First: 1 2 3 4 5 6 7 8 9 10 Second: 1 2 3 4 5 6 7 8 9 10
Third: 1 2 3 4 5 6 7 8 9 10 Fourth: 1 2 3 4 5 6 7 8 9 10
When did the condition(s)/concern(s) begin?:_____

The condition(s)/concern(s) is due to:

Injury Repetitive Use Weakness/Lack of Use Emotional Stress Unknown

Were you recently involved in an auto accident? No Yes If yes, date of the accident_____/_____/_____

The quality of the condition(s)/concern(s): Radiating Burning Dull/Aching Numb/Tingling Sharp/Stabbing

How often are you aware of the condition(s)/concern(s)?:

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Intermittent (0-25%)

What time of day is the condition(s)/concern(s)at its worst? Morning Evening Other:_____

The condition(s)/concern(s) has been: Getting Better Getting Worse Staying the Same

What makes the condition(s)/concern(s) **FEEL BETTER**?:_____

What makes the condition(s)/concern(s) **FEEL WORSE**?:_____

Who have you consulted for the condition(s)/concern(s)?:_____

Have you ever had similar condition(s)/concern(s)? Yes No

General Health & Lifestyle

Have you stopped doing any activities since the onset of the condition(s)/concern(s)? Yes No
Please list (if applicable):_____

What have you done to improve your state of health – body and/or mind? **Circle all that apply**

Massage Pilates Nutritional Supplements Weight Training/Lifting Running
Dietary Modifications Metabolic Detox/Cleanse Acupuncture Weight Loss Program
Meditation Family/Marriage/Personal Therapy Yoga Other Exercise:_____

Do you sleep well? Yes No
How many hours do you sleep?_____
Do you sleep on your stomach? Yes No
How many hours a day do you sit?_____
Are you currently on any medication? Yes No
Please list medications: _____

How many cups of coffee a day do you drink?_____
How many sodas a day do you drink?_____
How many glasses of water a day do you drink?_____
How many times a week do you eat fast food?_____

Please **circle** any of the following conditions that **YOU** have experienced:

Physical or Sexual Abuse	Food Sensitivity	Food Sensitivity
Recent Infection/Fever	Digestive Condition	Digestive Condition
Jaw Pain	Difficulty Concentrating	Stroke
Headaches	Kidney Condition	Weight Gain/Loss
Dizziness	Bladder Condition	Skin Condition

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Fainting Spells	Menstrual Issues	Arthritis
Seizures	PMS	Diabetes
Prolonged Fatigue	Prostate Condition	Cancer
Fibromyalgia	Asthma	Ringing of Ears
Blood Pressure Issues	Allergies	Sinus Condition
Thyroid Condition	HIV/AIDS	Attention Issues
Depression	Anxiety	Addiction Issues
Sexual Dysfunction	Heartburn	Vision Problems
Other muscle/joint pain	Sports Injury	High Cholesterol

WOMEN ONLY: Are you currently pregnant? Yes No

Family History

Please **circle** any of the following conditions that a **FAMILY member** has experienced:

Diabetes	Stroke	Cancer
Arthritis	Obesity	Anxiety
Depression	Blood Pressure Issues	High Cholesterol

Goal of Care with Health & Human Performance

Chiropractic is utilized for many different reasons from pain relief to complete wellness. What's your reason? Please **check** all that apply:

_____ Acute Care: Pain relief with no or minimal medication

_____ Corrective Care: Address the root cause to reduce risk of recurrence

_____ Wellness & Strength Care: Maintain optimum health and human performance

We are a multi-discipline practice that offers several different services to help patients reach their health and fitness goals. Would you like information on any of our following services? Please **check** all that apply:

____Massage Therapy	____One-on-one Yoga Lessons
____Kinesio Taping	____Custom-made Orthotics
____Acupuncture/Acupressure	____One-on-one Corrective Exercise
____ Reiki Energy Healing	____CrossFit Mobility & Performance Work

Patient Signature:_____ Date:_____

FOR STAFF OFFICE USE ONLY

Height:_____inches Weight:_____pounds