

# 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 cups of coffee a day do you drink?\_\_\_\_\_

How many hours do you sleep?\_\_\_\_\_

How many sodas a day do you drink?\_\_\_\_\_

Do you sleep on your stomach? Yes No

How many glasses of water a day do you drink?\_\_\_\_\_

How many hours a day do you sit?\_\_\_\_\_

How many times a week do you eat fast food?\_\_\_\_\_

Are you currently on any medication? Yes No

Please list medications:\_\_\_\_\_

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

Physical or Sexual Abuse

Food Sensitivity

Food Sensitivity

Recent Infection/Fever

Digestive Condition

Heart Condition

Jaw Pain

Difficulty Concentrating

Stroke

Headaches

Kidney Condition

Weight Gain/Loss

Dizziness

Bladder Condition

Skin Condition

**Continued on next page...**

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
ADD/ADHD	Autism	Asperger's
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 & fitness goals. Would you like information on any of our following services? Please **check** all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Massage Therapy            | <input type="checkbox"/> One-on-one Yoga Lessons              |
| <input type="checkbox"/> Kinesio Taping (Rock Tape) | <input type="checkbox"/> Cupping Therapy                      |
| <input type="checkbox"/> Acupuncture/Acupressure    | <input type="checkbox"/> Corrective Exercise                  |
| <input type="checkbox"/> Reiki Energy Healing       | <input type="checkbox"/> CrossFit Mobility & Performance Work |

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b><u>FOR STAFF OFFICE USE ONLY</u></b>	
Height: _____ inches	Weight: _____ pounds