ROCK REGENERATIVE SPORTS & SPINE THERAPY

PATIENT INTAKE FORM

Patient Name: _____ Date:_____

Nick Name: _____Social #:_____
Mailing Address:_____Apt #:_____
City: _____State: _____Zip:_____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Do you prefer to be reached by: Email Telephone
Date of Birth: _____/_____/_____Age: _____ Sex: M F
Are you: Minor Single Married Divorced Widowed
Spouse Name: _____
Number of Children: _____Children's Names:_____
Employment Status: Full time Part time Retired Unemployed Student Other
Your Employer:_____
Work Phone: _____Occupation: _____
If you are a College Student are you?: Full time Part time
Financially Responsible Party: Self Spouse Parent Other
Emergency Contact: (Name, Phone #) _____

Responsible Party

Name of Person Responsible for this account:_____
Relationship to Patient: _____Phone #_____
Address: _____City: _____Zip: _____
Name of employer: _____ Work # _____

Referral Source

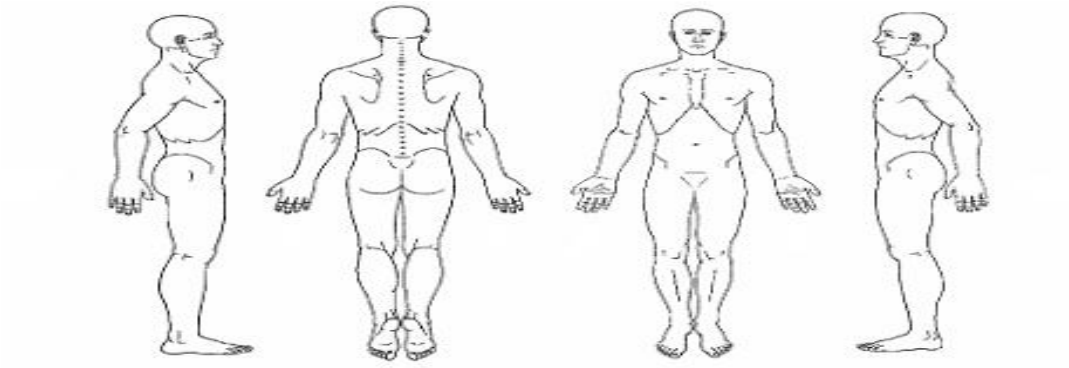
Were you referred by a patient of ours? Yes No
Patient's Name: _____
Were you referred by the internet? Yes No
If so, any particular directory or site? _____
Were you referred by: Doctor Referral Lecture / Screening MAC Other:
If so by who? _____

General Insurance Information

We will help you in any way we can for you to file your Insurance claim, however we do not accept insurance reimbursements for Sports Chiropractic Services. In the past, we have seen patients get back an average of 60-80% from their insurance carriers, If they have a PPO plan, and after the deductible is met. For more info on why we do not take insurance please refer to our website.

Name on the Insurance: _____
Insurance Company: _____Group #_____
Insurance Phone #:_____ PPO / HMO / Other___
How much is your Out of Network Deductible? _____
How much have you used? _____
Maximal Annual Out of Network Benefits:_____

1. Reason for the visit:_____
2. When did you first notice the symptoms?_____
3. Is today's problem caused by: ☐ Injury ☐ Auto Accident
4. Indicate on the drawings below where you have pain/symptoms



5. How often do you experience your symptoms?

☐Constantly (76-100% of the time) ☐Occasionally (26-50% of the time)
☐Frequently (51-75% of the time) ☐Intermittently (1-25% of the time)

6. How would you describe the type of pain?

☐Sharp ☐Numb
☐Dull ☐Tingly
☐Diffuse ☐Sharp with motion
☐Achy ☐Shooting with motion
☐Burning ☐Stabbing with motion
☐Shooting ☐Electric like with motion
☐Stiff ☐Other:_____

7. How are your symptoms changing with time?
☐Getting Worse ☐Staying the same ☐Getting Better

8. Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*please circle*)

7. How much has the problem interfered with your work?
☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely
8. How much has the problem interfered with your social activities?
☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

9. Who else have you seen for your problem?
☐Chiropractor ☐Neurologist ☐Primary care physician
☐ER Physician ☐Orthopedist ☐Other_____
☐Massage Therapist ☐Physical Therapist ☐No one
10. How long have you had this problem? _____

11. How do you think your problem began? _____
_____

12. Do you consider this problem to be severe?
☐Yes ☐No ☐Sometimes

13. What aggravates your problem? _____

14.What alleviates your problem?_____

15.What concerns you most about your problem? _____

16. What does it prevent you from doing?
_____

17.What is your: Height_____ Weight_____ Occupation_____

How would you rate your overall health?
☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

19. What type of exercise do you do?
☐Strenuous ☐Moderate ☐Light ☐None

20. Indicate if you have any immediate family members with any of the following:
☐Rheumatoid Arthritis ☐Diabetes ☐Lupus
☐Heart Problems ☐Cancer ☐ALS

Dates of Last Exams: _____
Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No
List any types of surgeries which you have had and the dates which they occurred:
_____
_____
Please list all Medications you are currently taking: _____
_____
Allergies: _____
Do you smoke? Yes No How much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
21. List all Supplements you are currently taking: _____

22. What activities do you do at work?

Sit	☐Most of the day	☐Half of the day	☐little to none
Stand	☐Most of the day	☐Half of the day	☐little to none
Computer Work	☐Most of the day	☐Half of the day	☐little to none
One the Phone	☐Most of the day	☐Half of the day	☐little to none

23.What activities do you do outside of work?_____
_____

24.Have you ever been hospitalized? ☐NO ☐YES

25.Have you seen a Chiropractor before? If yes, how long ago? What were the results? _____
_____

26.Have you had significant past trauma? ☐NO ☐YES

27.Anything else pertinent to your visit today? _____
_____

28. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present
☐	☐Headaches	☐	☐Abn. Weight Gain/Loss
☐	☐Neck Pain	☐	☐Loss of Appetite
☐	☐Upper Back Pain	☐	☐Abdominal Pain
☐	☐Mild Back Pain	☐	☐Ulcer
☐	☐Low Back Pain	☐	☐Hepatitis
☐	☐Shoulder Pain	☐	☐Liver/Gall Bladder Dis
☐	☐Elbow/Upper Arm Pain	☐	☐General Fatigue
☐	☐Wrist Pain	☐	☐Muscular Incoordination
☐	☐Hand Pain	☐	☐Visual Disturbances
☐	☐Hip Pain	☐	☐Dizziness
☐	☐Upper Leg Pain	☐	☐Diabetes
☐	☐Knee Pain	☐	☐Excessive Thirst
☐	☐ Lower Leg Pain	☐	☐Frequent Urination
☐	☐Ankle/Foot Pain	☐	☐Smoking/Tobacco Use
☐	☐Jaw Pain	☐	☐Drug/Alcohol Depend
☐	☐Joint Pain & Stiffness	☐	☐Allergies
☐	☐Arthritis	☐	☐Depression
☐	☐Rheumatoid Arthritis	☐	☐Systemic Lupus
☐	☐Cancer	☐	☐Epilepsy
☐	☐Tumor	☐	☐Dermatitis/Eczema
☐	☐Asthma	☐	☐HIV/AIDS
☐	☐Chronic Sinusitis	☐	☐Other_____
☐	☐High Blood Pressure		
☐	☐Heart Attack		
☐	☐Chest Pains		
☐	☐Stroke		**For Females Only**
☐	☐Angina	☐	☐Birth Control Pills
☐	☐Kidney Disorders	☐	☐Hormone Replacement
☐	☐Kidney Stones	☐	☐ Pregnancy
☐	☐Bladder infection		
☐	☐Painful Urination		
☐	☐Loss of Bladder Control		
☐	☐Prostate Problems		

Sports History

Were you active in sports? Yes No
Which one(s)? _____
Are you currently active in sports? Yes No

Which one(s)? _____
Have you been hurt in any of these Sports? Yes No
When/ How? _____

Chiropractic History

Have you ever received any form of Chiropractic Care? Yes No
If yes, who was your Chiropractor Practitioner? _____State: _____
If yes, for how long did you receive care? _____
If yes, how often did you go? _____
If yes, when was your last visit? _____
If you stopped, why did you stop? _____
Does anyone in your immediate family receive chiropractic care? Yes No

Diagnostic History

If possible bring your old diagnostic images and report with you when you come in for your apt
Has anyone ever taken imaging of your injured area? Yes No When? _____
Who has the images now? _____
What is that office's phone#_____

Have you had, or do you receive any of the following:
(Include……. When, How Often, Last Session)

Exercise Training: Yes No Massage: Yes No_____
Yoga: Yes No Acupuncture: Yes No _____
Other Modalities: Yes No_____

Authorization Consent

I Certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during or after the period of chiropractic care, to any third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered at the time of treatment on my behalf or my dependents behalf. I give permission to Dr. Bart Kennedy, D.C., C.C.S.P. to administer chiropractic treatment at Rock Sports and Spine therapy as explained to me, including the benefits and risks involved with the application of chiropractic manipulative therapy and the physical modalities used at this office. I also, agree that the Practice's Privacy Notice has been provided to me prior to my signing this Consent and that I read and fully understand it.

Patient Signature_____ Date_____