

Better Health, DC, MD.

New Patient Intake Form and Systems Review

NAME: _____ DOB _____ SSN: _____ DATE: _____
PHONE: _____ WORK: _____ EXT: _____ OCCUPATION: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
MARITAL STATUS: M S W D SPOUSE'S NAME: _____ SPOUSE'S DOB: _____
WHOM SHALL WE THANK FOR REFERRING YOU? _____

CHIEF COMPLAINT; THE REASON FOR THIS APPOINTMENT:

1. _____

What treatment(s) have you had for these conditions? _____

Are any of these conditions due to: ___Auto Accident? When? ___ / ___Work? When? _____

How long have you had the complaint? _____

Circle the intensity of your pain: (0= no pain, 10 worst pain you can imagine) 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms generally: ___ Getting better ___ Getting Worse ___ About the same?

Does the pain radiate? (travel) ___ Yes ___ No If yes, describe _____

Have you had this or similar complaints before? ___ Yes ___ No When _____

How much time was lost from work due to your present complaint? _____

Date returned to work: _____

Habits

Table with 4 columns: Do You, Yes, No, Daily Consumption. Rows include Smoke, Drink Coffee, Drink Alcohol, Drink Beer, Recreation Drugs.

Operations you have had: Year

Previous Hospitalizations: Year

Medications you are currently taking:

Drug Allergies:

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Better Health, DC,MD.

BODY SYSTEMS REVIEW

CIRCLE CURRENT PROBLEMS ○ AND CHECK ✗ PAST PROBLEMS

<p style="text-align: center;">General</p> <p>Fatigue Fever Night Sweats Unexplained Weight Change Headaches</p> <p style="text-align: center;">Eyes</p> <p>Eye Pain Double vision Corrective Lenses</p>	<p>Do Not Write in This Space</p>	<p style="text-align: center;">Back / Neck/ Skeleton</p> <p>Scoliosis (Curvature of Spine) Fractures of the Spine Other Broken Bones Thinning of Bones Osteoarthritis Rheumatoid Arthritis</p>	<p>Do Not Write In This Space</p>		
<p style="text-align: center;">Ears/ Nose/Throat</p> <p>Ringing /Buzzing Ear Pain Ear Infections Sinus or Nasal Problems Sores in the Mouth Hoarseness Difficulty in Swallowing Coated Tongue</p>		<p style="text-align: center;">GU/ Reproductive</p> <p>Women: Last Menstrual Period? Any Miscarriages? # of Pregnancies? # of Live Births?</p> <p>Men: Loss of sexual activity? How Long? Discharge from Penis? Prostate trouble? Trouble Urinating?</p>			
<p style="text-align: center;">Heart /Lungs</p> <p>Chest pain Shortness of Breath Cough Waking Up Short of Breath Wheezing Skipped Heart Beats Ankle Swelling</p>		<p style="text-align: center;">Nerve System</p> <p>Seizures/convulsion Loss of Consciousness Burning/Numbing pain in hands and/or feet Weakness of one arm or leg or both arms or legs Balance problems/vertigo</p>			
<p style="text-align: center;">Abdomen</p> <p>Abdominal Pain Nausea Vomiting Diarrhea Bright Red Blood in Stools Dark Red Blood in Stools Vomiting Blood Frequent Heartburn Food that Upset Your Stomach</p>		<p style="text-align: center;">Family History</p> <p>Father Mother Brothers/Sisters 1. M F 2. M F 3. M F 4. M F Husband/Wife Sons/Daughters 1. M F 2. M F 3. M F 4. M F</p>	<p style="text-align: center;">Age</p>	<p style="text-align: center;">Health Good/Fair/Poor</p>	<p style="text-align: center;">Deceased Age/Cause</p>
<p style="text-align: center;">Any blood relatives who have/had any of the listed conditions?</p> <p>Asthma Y N Relationship: Arthritis Y N Relationship: Allergies Y N Relationship: Anemia Y N Relationship: Alcoholism Y N Relationship: Bleeding Tend. Y N Relationship: Cancer Y N Relationship: Colitis Y N Relationship: Congenital Heart Y N Relationship: Diabetes Y N Relationship: Epilepsy Y N Relationship: High BP Y N Relationship:</p>		<p>Heart Disease Y N Relationship: Kidney Disease Y N Relationship: Leukemia Y N Relationship: Migraine Y N Relationship: Obesity Y N Relationship: Stroke: Y N Relationship: Suicide Y N Relationship: Stomach Ulcers Y N Relationship: Tuberculosis Y N Relationship:</p>			