ctintake

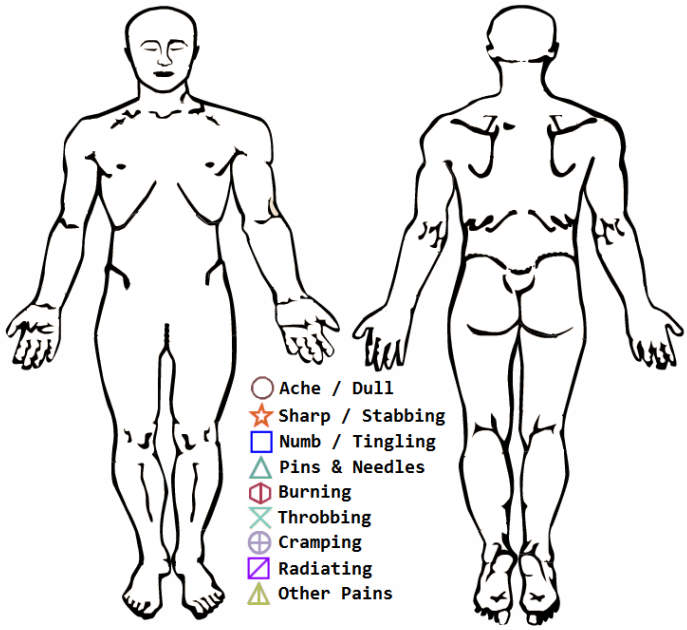
7417 Jefferson Highway
Baton Rouge, LA 70806
225.924.3989

5935 Commerce St.
St. Francisville, LA 70775
225.635.4172

## Patient Information:

| | | | | | |
|---|---|---|---|---|---|
| Date | | SSN | | Birthday | |
| First Name | | Middle Name | | Last Name | |
| Sex | ◯ Male ◯ Female | Height | | Weight | |
| Married/Civil Union: | | Spouse Name | | # of Children | |
| Home # | | Cell # | | Work # | |
| Address | | | | | |
| City | | State | | Zip | |
| Emergency Contact | | Emergency Relation | | Emergency Phone | |
| Email | | | | | |

## Patient Symptoms:




## Patient Social

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never | Caffeine: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never |
| Diet Food Products: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never | Drugs: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never |
| OTC Stimulants: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never | Exercise: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never |
| Homemade Food: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never | Processed: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never |
| Soft Drinks: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never | Tobacco: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never |
| Water: | ◯ Daily | ◯ Weekly | ◯ Occasionaly | ◯ Never | | | | | |

## Chiropractic Experience:

Who referred you to our office: _____

Where did you hear about us? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Mailing ☐ Community Event ☐ Other _____

Have you been adjusted by a chiropractor before? ○ Yes ○ No If yes, Why? _____

Doctor's Name: _____ Approximate Date of Visit _____

## Employer Information:

Employed: _____ Employer Name _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

## Reason for this Visit:

Describe the reason for this visit?

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

## Complaint Information:

Injury Occurred: ◯ Work ◯ Automobile ◯ Third-Party ◯ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Interfere w/ Activities: ◯ Yes ◯ No Affected Sleep: ◯ Yes ◯ No Frequency: _____

Missed Work: ◯ Yes ◯ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ◯ Yes ◯ No Explain: _____

Reduced Work: ◯ Yes ◯ No Explain: _____

Does it Worsen: ◯ Yes ◯ No Explain: _____

Weather Affects it: ◯ Yes ◯ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯ Yes ◯ No Explain: _____

X-rays Taken: ◯ Yes ◯ No Explain: _____

Pain level Rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same Condition Before: ◯ Yes ◯ No Date: _____ Practitioner: _____

## Insurance Information:

Payment Name _____ Primary Phone # _____ Primary ID/Policy _____

Payment Address _____

Payment City _____ Payment State _____ Payment Zip _____

Primary Group # _____ Primary Name _____ Primary DOB _____

Secondary Name _____ Secondary Phone # _____ Secondary ID/Policy _____

Secondary Address _____

Secondary City _____ Secondary State _____ Secondary Zip _____

Secondary Group # _____ Secondary Name _____ Secondary DOB _____

Claim # _____ Claim Contact _____ Claim # _____

Attorney Name _____ Attorney Phone # _____

## Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the Doctor to select the type of care appropriate for my condition

☐ Relief care: Symptomatic relief of pain or discomfort.

☐ Corrective care: Correcting and relieving the cause of the problem as well as the symptom

☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

## Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯ Yes ◯ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ◯ Yes ◯ No Planning: ◯ Yes ◯ No

Medications: _____

Supplements: _____

## Personal Incident History:

Broken Bones: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Sprains/Strains: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Hospitalized: ◯ Yes ◯ No Explain: _____

Surgery: ◯ Yes ◯ No Explain: _____

Auto Accident: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Struck Unconscious: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Eating Disorder: ◯ Yes ◯ No Explain: _____

Stroke: ◯ Yes ◯ No Explain: _____

## Health Checklist:

| | | |
|---|---|---|
| ☐ Allergies | ☐ Alcoholism | ☐ Anemia |
| ☐ Arteriosclerosis | ☐ Arthritis | ☐ Asthma |
| ☐ Back Pain | ☐ Breast Lump | ☐ Bronchitis |
| ☐ Bruise Easily | ☐ Cancer | ☐ Chest Pain |
| ☐ Cold Extremities | ☐ Constipation | ☐ Cramps |
| ☐ Depression | ☐ Diabetes | ☐ Digestion Problems |
| ☐ Dizziness | ☐ Excessive Menstruation | ☐ Eye Pain or Difficulties |
| ☐ Fatigue | ☐ Frequent Urination | ☐ Headache |
| ☐ Hemorrhoids | ☐ Venereal Disease | ☐ Hot Flashes |
| ☐ Irregular Heart Beat | ☐ Irregular Menstrual | ☐ Kidney Infection |
| ☐ Kidney Stones | ☐ Loss of Memory | ☐ Loss of Balance |
| ☐ Loss of Smell | ☐ Loss of Taste | ☐ Nosebleeds |
| ☐ Pacemaker | ☐ Polio | ☐ Poor Posture |
| ☐ Prostate Trouble | ☐ Sciatica | ☐ Shortness of Breath |
| ☐ High Blood Pressure | ☐ Sinus Infection | ☐ Insomnia |
| ☐ Spinal Curvatures | ☐ Stroke | ☐ Swelling of Ankles |
| ☐ Swollen Joints | ☐ Thyroid Condition | ☐ Tuberculosis |
| ☐ Ulcers | ☐ Varicose Veins | |

## Family Health History:

Family Health History

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____