NEW PATIENT INTAKE

Name: _____ Todays Date: _____

Address:_____ City_____ State_____ Zip_____

Home telephone ( ) _____ Work ( ) _____ Cell ( )_____

Email Address: _____ Male ☐ Female ☐

Social Security # _____Birth Date:_____ Age:_____

Occupation:_____

Employer Name and Address:_____

Single ☐ Married ☐ Spouse's Name_____

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, when_____

Whom may we thank for referring you to our office?_____

****WHAT IS YOUR CURRENT COMPLAINT?**_____

PLEASE Check all the symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problems urinating	☐ Heart burn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability:_____.

The statement made on this form are accurate to the best of my recollections and I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____

Guardian Signature_____ Date_____

Dr. John Austria - Austria Chiropractic

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