Greenlee
CHIROPRACTIC
& Acupuncture Clinic

Patient Intake Form

1 Contact Information

____
Date

______________________ ______________________ ______ ______/______/______
Last Name First Name MI Date of Birth

______________________ ______________________ ______ ______
Street Address City State Zip

______________________ ______________________ ______________________
Home Phone Cell Phone Work Phone

It is our policy to conduct reminder phone calls one day prior to your appointment. No confidential information will be disclosed in this call. We will leave a message on your voicemail or with the person who answers your phone. If you do **not** wish to receive a reminder phone call, please sign here: ________________________

______________________ ______-______-______
Email Address SSN

______________________ ______________________ ______________________
Employer Address Job Title

______________________ ______________________
Spouse's Name Date of Birth of Insurance Policyholder

______________________ ______________________
Referred by Other family members seen here

______________________ ______________________ ______________________
Emergency Contact Relationship Phone Number

2 Reason for Visit

Symptoms began on: ☐☐☐

1. Briefly describe your symptoms: ____

____

2. How did your symptoms start? ____

____

3. Average pain intensity:

Last 24 hours: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

Past week: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

4. How often do you experience your symptoms?

☐ Constantly (76% - 100% of the time) ☐ Frequently (51% - 75% of the time) ☐ Occasionally (26% - 50% of the time) ☐ Intermittently (0% - 25% of the time)

5. How much have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. In general, would you say your overall health right now is….

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

3 Health History

Previous Surgeries and Dates

Current Medications

Allergies

Have you had any of the following medical conditions? (Check only those that apply)

- ☐ Fainting/Seizures/Epilepsy
- ☐ Psychiatric Problems
- ☐ Cancer
- ☐ Fatigue
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Venereal Disease
- ☐ Shingles
- ☐ HIV/AIDS
- ☐ Thyroid Problems
- ☐ Low back problems
- ☐ Arthritis/bursitis/tendonitis
- ☐ Migraines
- ☐ Sinus Problems
- ☐ Glaucoma
- ☐ Hearing Problems
- ☐ Emphysema
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Kidney Problems
- ☐ Prostrate trouble
- ☐ Ulcers
- ☐ Heart surgery
- ☐ Pacemaker
- ☐ Heart murmur
- ☐ Artificial Valves
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Congenital heart failure
- ☐ Other: ____________________

Consent
I authorize Greenlee Chiropractic & Acupuncture Clinic Inc to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.

Signature Date

Parent/Guardian Signature Date

HIPAA Notification
Greenlee Chiropractic and Acupuncture Clinic, Inc. has provided me access to the HIPAA Privacy Notice. I understand my rights contained in the notice. By way of my signature, I provide Greenlee Chiropractic and Acupuncture Clinic, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Signature Date

Parent/Guardian Signature Date