ATLANTIC CHIROPRACTIC
PHONE: 302-422-3100 ✲ ACA-DE.COM ✲ FAX: 302-422-2900

New Condition Intake Form

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (check one) **Sex:** ☐ Male ☐ Female **Date**: _____ /_____/_____

First Name: _____ Middle Initial: _____ **Last Name:** _____

Date of Birth: _____/_____/_____ Age: _____ **Email:**_____

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile/Home Phone: (_____) _____-_____

Primary Medical Provider: _____ Practice/Facility:_____ City:_____

Orthopedist / Neurologist: _____ Practice/Facility:_____ Date seen: _____

[Please notify the front desk if you have had any imaging related to this complaint.]

Patient Employer Data:
Employment Status: ☐ Employed (☐ FT/ ☐ PT) ☐ Student ☐ Retired ☐ Homemaker ☐ Unemployed

Employer Name: _____

Address Line: _____ City: _____ State:_____

Job Title/Position:_____ Physical work duties: _____

Marital Status: ☐ Single ☐ Married ☐ Other_____ Is your spouse a patient in the clinic? ☐Yes ☐ No

Spouse Data:
First Name: _____ Middle: _____ Last Name: _____

Phone: (_____) _____-_____

Emergency Contact:
Contact Name: _____ Relationship:_____

Phone:(_____)_____-_____

For Office Use Only: (Staff: _____)

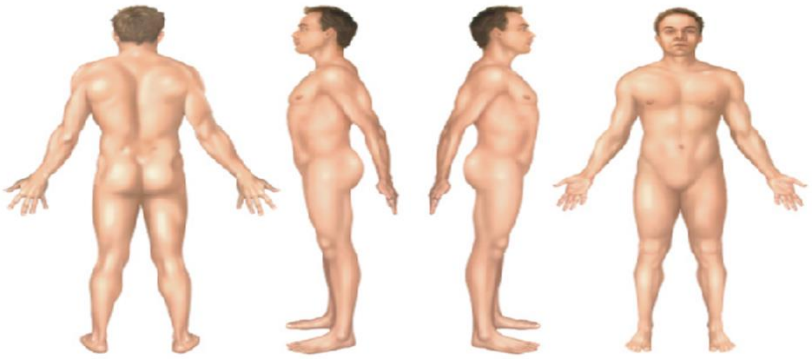
Height: _____ Weight: _____ BP: _____ Pulse: _____

Current Area(s) of Complaint:

Please Circle:	Left/Right	Please grade your pain on a scale of 0-10: [0= No Pain, 10= Extreme Pain]	Choose how frequent the pain is present: Occasional - Intermittent - Frequent - Constant (0 – 25%) (26 – 50%) (51 – 75%) (76 – 100%)
Neck	**L / R**	0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐
Upper Back	**L / R**	0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐
Mid Back	**L / R**	0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐
Low Back	**L / R**	0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐
_____ (Other)	**L / R**	0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐

(Staff use only)

**** Please mark where your pain/symptoms are: ****



When did this episode start? _____

Do you know the cause of your complaint? _____

Do you have any pain / symptoms that extend into arms / legs? ☐ Yes ☐ No
Explain:_____

Are symptoms worse in the morning / afternoon / evening / night? ☐ Yes ☐ No
Explain: _____

Circle the quality of your symptoms:

- Sharp
- Achiness
- Headache
- Muscle spasm
- Stiffness
- Tightness
- Dull
- Discomfort
- Losing balance
- Numbness
- Swelling
- Tingling
- Throbbing
- Dizziness
- Loss of flexibility
- Unsteadiness
- Tenderness
- Weakness

Other symptoms:_____

Circle the activities that aggravate your condition:

- Driving
- Bending
- Sitting
- Lifting
- Walking
- Sports
- Standing
- Working
- Sleeping
- Twisting

Other aggravating factors: _____

Circle activities that relieve your condition:

- Rest
- Heat
- Pain meds
- PT
- Movement
- Dry Needling
- Elevation
- Stretch
- Chiropractic
- Ice
- NSAIDs
- Massage
- Acupuncture

Other relieving factors: _____

Can you go to sleep without problems? ☐ Yes ☐ No
Do you wake up because of pain? ☐ Yes ☐ No
If yes, where is the pain that wakes you up? _____

Family History:

Cancer: _____	Parent	Sibling	Grandparent
High Blood pressure:	Parent	Sibling	Grandparent
Heart attack:	Parent	Sibling	Grandparent
Diabetes:	Parent	Sibling	Grandparent
Stroke:	Parent	Sibling	Grandparent
Osteoarthritis:	Parent	Sibling	Grandparent
Other:_____	Parent	Sibling	Grandparent

Medical History:

Have you seen other providers for THIS condition? ☐ Yes ☐ No
If yes, what specialty? ☐ Chiropractic ☐ Medical ☐ Physical Therapy ☐ Other:_____
Please list all providers (Name and Facility/Practice) : _____
_____

Have you ever had chiropractic care before for any reason? ☐ Yes ☐ No
If yes, where?_____

Prior Imaging (X-rays, MRIs, etc.):

- **Imaging related to THIS condition:**_____
- **All other imaging in last 2 years:** _____

Medical Conditions/Procedures you have had or are currently being treated for:
☐ High Blood Pressure ☐ Diabetes ☐ Stroke / TIA ☐ Vascular Conditions ☐ Pain Management
☐ Spine Surgery ☐ Other:_____
Do you have a pacemaker? ☐ Yes ☐ No

Prior Hospitalizations (other than surgeries):_____
_____

Medications:

- **Medications for THIS condition**: _____
- **All other medications:** _____
_____

Supplements:_____
_____

Allergies:_____

Prior Trauma (falls, fractures, injuries):_____

_____

Prior Auto Accidents or Work Injuries:_____

_____

_____

Surgeries (including spinal surgeries):

- **Surgeries related to THIS complaint:**_____
- **All other surgeries (list surgery and year performed):**_____

_____

Female only:

Date of last menstrual cycle:_____ Currently pregnant? Yes No Unsure

Have you had children? ☐Yes ☐ No If yes, how many? _____

Social Information:

Do you currently smoke? ☐Yes ☐ No If yes, how long: _____ Packs/Day: _____

If no, have you ever smoked? ☐Yes ☐ No

How many alcoholic beverages do you consume per week? _____

Medical/Recreation Marijuana use? ☐Yes ☐ No Frequency: _____

How many days per week do you exercise? _____ How many minutes per day? _____

Type of exercise: _____

Review of Systems:

Constitutional	**Now**	**Past**	**Never**
Fever:	☐	☐	☐
Poor appetite:	☐	☐	☐
Weakness:	☐	☐	☐
Weight loss/gain:	☐	☐	☐

Eyes			
Blurred vision:	☐	☐	☐
Change in vision:	☐	☐	☐
Glasses:	☐	☐	☐

Ear/Nose/Throat/Mouth			
Difficulty hearing:	☐	☐	☐
Earache:	☐	☐	☐
Ear infection:	☐	☐	☐
Sinus problem:	☐	☐	☐
Sore throat:	☐	☐	☐

Cardiovascular			
Chest pain:	☐	☐	☐
High blood pressure:	☐	☐	☐
Irregular heartbeat:	☐	☐	☐
Swelling of legs:	☐	☐	☐

Respiratory	**Now**	**Past**	**Never**
Blood in sputum:	☐	☐	☐
Frequent cough:	☐	☐	☐
Shortness of breath:	☐	☐	☐
Wheezing:	☐	☐	☐

Gastrointestinal			
Abdominal pain:	☐	☐	☐
Blood in stool:	☐	☐	☐
Constipation:	☐	☐	☐
Diarrhea:	☐	☐	☐
Nausea/Vomiting:	☐	☐	☐

Genitourinary			
Blood in urine:	☐	☐	☐
Painful urination:	☐	☐	☐
Urinary frequency:	☐	☐	☐

Musculoskeletal			
Stiffness:	☐	☐	☐
Joint pain:	☐	☐	☐
Balance problems:	☐	☐	☐
Osteoporosis:	☐	☐	☐

Skin	**Now**	**Past**	**Never**
Change in color:	☐	☐	☐
Lump / growth:	☐	☐	☐
Skin rash:	☐	☐	☐

Neurological			
Dizzy spells:	☐	☐	☐
Headaches:	☐	☐	☐
Migraines:	☐	☐	☐
Numbness/tingling:	☐	☐	☐
Seizures:	☐	☐	☐
Slurred speech:	☐	☐	☐
Stroke:	☐	☐	☐
Weakness:	☐	☐	☐

Psychiatric			
Depression:	☐	☐	☐
Memory loss/forgetful:	☐	☐	☐

Hematologic/Lymphatic			
Anemia:	☐	☐	☐
Clotting problems:	☐	☐	☐
Easy bruising/bleed:	☐	☐	☐

**** Patient Signature:**_____ **Date:**_____

Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependent during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient Date

Please list below any family/friend whom we may inform about your care, treatment, medical condition, and payment:

Name	Relationship	Phone
Name	Relationship	Phone

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, most credit cards and Care Credit are accepted.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered**. We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependent to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

_____

Signature of Patient or Parent/Guardian of Minor Patient

Patient Name: _____

Patient #: _____ **Date:** _____

Dr. Andrew Riddle
Dr. Lauren Hitchens
Dr. Gary Morgan
Dr. Cliff Renyo
Dr. Crystal Crate
Dr. Meg Van de Loo

ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.
Gentle Effective Care for All Ages.

Phone: (302) 422-3100
Fax: (302) 422-2900
ACA-DE.com

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FOR USE AND DISCLOSURE

Patient Name:_____ DOB:_____

I hereby authorize (Full name of Physician and/or Facility): _____

to release my individually identifiable Protected Health Information (PHI) to Atlantic Chiropractic Associates, P.A. (ACA) at 509 Lakeview Avenue., Milford, DE 19963 to use and disclose for the specific purpose of **diagnosis, treatment, and payment**. I understand that my PHI may be redisclosed by any person or entity receiving my PHI from ACA. I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form.

THE FOLLOWING PHI IS TO BE RELEASED: (PATIENT OR PATIENT REPRESENTATIVE MUST CHECK ONE BOX FOR EACH ITEM):

Yes	No	Items Requested	Yes	No	Items Requested	Yes	No	Items Requested
☐	☐	Physician Notes	☐	☐	CT Scans	☐	☐	All Medical Records on file
☐	☐	X-Ray Reports	☐	☐	Lab Results	☐	☐	Other: _____
☐	☐	MRI Scans	☐	☐	Claims/Billing Information			

The authorization will expire on (date no more than one year in advance): _____

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying ACA in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by ACA in reliance on this authorization before ACA receives my request for revocation or modification. I must sign and date my written request and send it to the following address:

Medical Records Department
Atlantic Chiropractic Associates, P.A.
509 Lakeview Avenue
Milford, DE 19963

Signature of Patient or Patient Representative: _____Date:_____

If you are signing as the patient's representative, print your name: _____

Please indicate your relationship to the patient:

☐ Parent, guardian or caregiver of a minor patient.

☐ Guardian or conservator of an incompetent patient.

☐ Beneficiary or personal representative of a deceased patient.

Other: _____(Specify Relationship)