

PATIENT INTAKE FORM

PATIENT INFORMATION

1. Today's Date _____
2. Title: Mr. Mrs. Ms. Dr. Other _____
3. **Name** _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)
4. SSN# _____-_____-_____
5. Gender: M F
6. **Date of Birth** ____/____/____
7. Occupation _____
8. Employer _____
9. Marital Status: Single Married Divorced
 Separated Widowed
10. Spouse's Name _____
11. How did you hear about us?
 Referral, Who? _____
 Internet Walk-In ZocDoc Event
 Other _____

CONTACT INFORMATION

1. Email _____
2. Address _____
(CITY) (STATE) (ZIP)
3. Which number would you prefer we contact?
 Home Phone (_____) _____-_____
 Work Phone (_____) _____-_____
 Cell Phone (_____) _____-_____
 Cell Carrier _____
4. Appointment reminder option:
 Email Text Message Both
5. **In case of emergency, contact**
 Name _____
 Phone (_____) _____-_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company provided and assign directly to Dr. Stephanie Woo all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the provided insurance company(ies) and their agents for all purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PRINT name of Patient, Parent, Guardian or Personal Representative

SIGNATURE of Patient, Parent, Guardian or Personal Representative

← SIGN HERE

_____/_____/_____
DATE

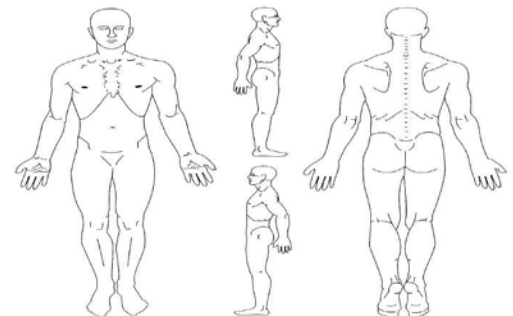
ACCIDENT INFORMATION

1. Is your condition related to an accident? No, skip this section Yes, Date ____/____/____
2. Type of accident: Auto Work Home Other _____
3. To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other _____
4. Attorney Name (if applicable) _____

PATIENT CONDITION

1. Reason for visit _____
2. When did your symptoms appear? _____
3. Rate your pain level: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
4. Type of pain: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling
5. How often do you have this pain? _____
6. Does it interfere with your: Work Sleep Daily Routine Recreation
7. Activities type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting
8. Activities or movements that are painful to perform:
 Sit Stand Walk Bend Lying Down

Below, please **mark** any pain or symptom area(s) below:



(Continue on back)

HEALTH HISTORY

1. If any, what treatment have you already received for your condition? Medication Surgery Physical Therapy
 Chiropractic None Other _____

2. Name/address of the doctor(s) who have treated you for your condition _____

3. Date of Last: Physical Exam ____/____/____ Spinal X-Ray ____/____/____ Blood Test ____/____/____
 Spinal Exam ____/____/____ Chest X-Ray ____/____/____ Urine Test ____/____/____
 Dental X-Ray ____/____/____ MRI, CT-Scan, Bone Scan ____/____/____

4. Please mark if you have had any of the following:

AIDS/HIV _____	Diabetes _____	Liver Disease _____	Rheumatoid _____
Alcoholism _____	Emphysema _____	Measles _____	Arthritis _____
Allergy Shots _____	Epilepsy _____	Migraines _____	Rheumatic Fever _____
Anemia _____	Fractures _____	Miscarriage _____	Scarlet Fever _____
Anorexia _____	Glaucoma _____	Mononucleosis _____	Stroke _____
Appendicitis _____	Goiter _____	Multiple Sclerosis _____	Suicide Attempt _____
Arthritis _____	Gonorrhea _____	Mumps _____	Thyroid Problems _____
Asthma _____	Gout _____	Osteoporosis _____	Tonsillitis _____
Bleeding Disorders _____	Heart Disease _____	Pacemaker _____	Tuberculosis _____
Breast Lump _____	Hepatitis _____	Parkinson's _____	Tumors _____
Bronchitis _____	Hernia _____	Disease _____	Typhoid Fever _____
Bulimia _____	Herniated Disk _____	Pinched Nerve _____	Ulcers _____
Cancer _____	Herpes _____	Pneumonia _____	Vaginal Infections _____
Cataracts _____	High _____	Polio _____	Venereal Disease _____
Chemical _____	Cholesterol _____	Prostate Problem _____	Whooping Cough _____
Dependency _____	Kidney Disease _____	Prosthesis _____	Other _____
Chicken Pox _____		Psychiatric Care _____	

EXERCISE LEVEL None Moderate Daily Heavy

WORK ACTIVITY Sitting Standing Light Labor Heavy Labor

HABITS Alcohol (____ drinks/day) Coffee/Caffeine Drinks (____ cups/day)
 Smoking (____ packs/day) High Stress Level (Reason: _____)

If Female, are you pregnant? No Yes, due date ____/____/____

PREVIOUS INJURIES/SURGERIES (if applicable)

	Description	Date
<input type="checkbox"/>	Falls _____	____/____/____
<input type="checkbox"/>	Dislocations _____	____/____/____
<input type="checkbox"/>	Broken Bones _____	____/____/____
<input type="checkbox"/>	Head Trauma _____	____/____/____
<input type="checkbox"/>	Surgeries _____	____/____/____
<input type="checkbox"/>	Other _____	____/____/____

MEDICATIONS

 Pharmacy Name _____
 Pharmacy Phone (____)____-____

ALLERGIES

VITAMINS/HERBS/MINERALS

FOR OFFICE USE ONLY

Doctor's Notes

