Brannon Family Chiropractic
197 E. Brannon Road
Nicholasville, KY 40356
859-971-0370
www.brannonfamilychiro.com

NEW PATIENT INTAKE FORMS

ABOUT YOU

Name _____

Street Address _____

Address Line 2 _____

City _____ **State** _____ **Zip** _____

Mobile # ____ - ____ - ____ **Work #** ____ - ____ - ____ **Home #** ____ - ____ - ____

Email Address _____

DOB _____/_____/_____ **Gender** ☐ Male ☐ Female

Height _____ ft. _____ in. **Weight** _____ lbs.

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouses Name** _____

EMERGENCY CONTACT INFORMATION

Name _____

Phone # ____ - ____ - ____ **Relation to You** _____

REFERRAL INFORMATION

Referring Physician _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us? ☐ Word of Mouth ☐ Advertisement ☐ Social Media

☐ Direct Marketing ☐ Internet ☐ Other

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REASON FOR VISIT

Date of Scheduled Appointment _____ / _____ / _____

Chief Complaint _____

How long have you had this complaint? ☐ < 5 days ☐ 5-30 days ☐ > 30 days

Cause of condition _____

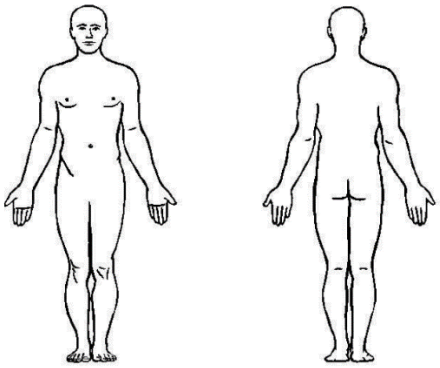
Date condition began (skip if due to accident) _____ / _____ / _____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

_____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Same ☐ Improved

What activity is most significantly affected by this discomfort? _____

_____

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REASON FOR VISIT (CONT'D)

What treatment have you received for this condition up to now? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscle, Bones or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose, or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma, or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels, or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid, or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Allergies or Sensitivities	☐ No	☐ Yes	**Explain:** _____

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PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures?	☐ No	☐ Yes	**Explain:** _____
Are there any past illnesses or conditions we should be aware of?	☐ No	☐ Yes	**Explain:** _____
Do you have a past history of accidents or trauma?	☐ No	☐ Yes	**Explain:** _____
Are you currently taking any medication?	☐ No	☐ Yes	**Explain:** _____
Do you have any family illness history that we should be aware of? (diabetes, cancer, hypertension, etc.)	☐ No	☐ Yes	**Explain:** _____

WORK AND SOCIAL HABITS

Select all that apply below:

Current work habits	☐ Permanently fully disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition ☐ Full-time (20-40+ hours per week) ☐ Part-time (1-19 hours per week) ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed
Personal social habits	☐ Smoke or use tobacco products ☐ Drink alcohol ☐ Drink caffeine ☐ Use recreational drugs ☐ Other, to be discussed with doctor
Present exercise habits	☐ No current exercises ☐ Exercise daily ☐ Exercise 3+ times per week ☐ Cannot exercise due to current condition
Diet and nutrition habits	☐ Vegan or vegetarian ☐ Daily supplements ☐ Other **Explain:** _____

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INFORMED CONSENT TO TREAT

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.

I understand Brannon Family Chiropractic Privacy Practices. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, the right to object to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Patient Signature _____ **Date** _____ **/** _____ **/** _____