SWISS COVE FAMILY CHIROPRACTIC
PROVERBS 16:3

Dr. M Bailey Suarez DC, PLLC
445 State Road 13 STE 9
P: (904) 429 – 7490

NEW ADULT PATIENT INTAKE FORM

Patient Data

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _______

Name ______________________ Middle Initial ______ Last Name __________________________

Date of Birth ______/______/_______ Social Security Number: ______-_____-______

Sex: Male Female Marital Status: Single Married Divorced

Address ____

City _______________________________ State __________________ Zip Code ______________

Cell Phone (_____) ________-___________ Work Phone (_____) _________-____________

Email ____
Consent to receive emails &/or text messages Yes No

Employment Status: Employed Unemployed FT Student PT Student Other_____

Spouse Data

First Name ___________________ Middle Initial _____ Last Name _________________________

Cell Phone (_____) _______-__________ Work Phone (_____) _________-____________

Emergency Contact

Contact Name ____________________________ Relationship to Patient ___________________

Cell Phone (_____) _______-________ Work Phone (_____) ________-______________

Employer Data

Name ____

Your Occupation _________________________ Your Job Description _____________________

Address ____

City ________________________________ State _________________ Zip Code ______________

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Medical History

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _______________			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _______________			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other __________

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never
Other _________________			

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other __________________		

Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _________________			

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Review of Systems – (Check box if you have had trouble with any of the following, **circle NO if none**)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

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Are you using any recreational drugs: □ YES □ NO

Are you taking any vitamins/supplements? □ NO □ YES, please list vitamins/supplements (be specific) you are currently taking along with dosage.

*If you have a med list, we can copy it for you instead

Vitamin/Supplement: ______________________________ Dosage: ______________________________

Vitamin/Supplement: ______________________________ Dosage: ______________________________

Vitamin/Supplement: ______________________________ Dosage: ______________________________

Are you taking any medications? □ NO □ YES, please list medications (be specific) you are currently taking along with dosage.

*If you have a med list, we can copy it for you instead

Medication: ______________________________ Dosage: ______________________________

Medication: ______________________________ Dosage: ______________________________

Medication: ______________________________ Dosage: ______________________________

Are you allergic to any Medications? □ NO □ YES, please list medications you are allergic to and the problem experienced:

Medication: ______________________________ Reaction: ______________________________

Medication: ______________________________ Reaction: ______________________________

Medication: ______________________________ Reaction: ______________________________

Are you sexually active? □ NO □ YES, how many partners? _____________

Women ONLY

Are you pregnant? YES NO **Are you trying to get pregnant?** YES NO

Last date of menstrual period: ____/_____/_____ **Are you using birth control?** YES NO

Are your periods regular? YES NO, **please describe cycle:** ______________________________

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Employment, ADL, and Recreation Information

Condition's Effect on Job Performance:

☐ **No Effect** ☐ **Mild** (painful, but can do) ☐ **Mod** (painful limited ability) ☐ **Severe** (unable to do limited duty)

Daily Activities: Effects of Current Condition on Performance

Activity				
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Changing Position: (sit to stand, laying down, rising up)	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reaching up:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting/Holding Child :	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Running/Exercising:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climbing Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self-Care	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Caring for Others:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

How did you hear about our office? ____

____

Who can we thank for your referral to us?

Name:_______________________________________ Phone:_____________________________

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name: ____

Patient's Signature: ______________________________________ **Date:** _________________

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Payment/Insurance Information

Who is responsible for your bill? Self Pay Health Insurance Medicare Worker's Comp Auto Insurance Other ________________________

Health Insurance Carrier: _______________________ Insurance Card ID # ___________________

Policy Holder's Name: ________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Primary Care Physician __________________

**We are NOT in network with any Health Insurance Companies. However, we will provide a super bill of services our doctor provided for you upon your written request. Please refer to our financial policy for additional information.*

Worker's Compensation Injury / Auto / Personal Injury

Is your injury a result from an accident at work or auto collision? Auto Work Personal Injury

Please fill out Accident Questionnaire! *(Ask the front desk for this form if not included with your paperwork.)*

When did the accident occur? Date: ____/____/____ Time: ____:____am / pm

In motor vehicle accidents, was a police report filed? Yes No

Have you filed a report with your auto insurance company? Yes No

Insurance company name: _________________________________**Claim #** _______________________

In WC/PI cases, have you filed an injury report with your employer? Yes No

Attorney name: ____ **Phone #** _______________________

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