CHIROPRACTIC
restoration health

Restoration Health Chiropractic

Daniel Martingano, DC

Initial Intake Form

1320 Palm Bay Rd., Palm Bay FL 32905

ABOUT YOU

First Name:	Middle Name:	Last Name:
Street Address:		
Address Line 2:		
City:	State:	Zip:
Mobile Phone:	Work Phone:	Home Phone:
Email Address:		Date of Birth:
Gender:	Height:	Weight:
Marital Status: O Single O Married O Separated O Divorced O Widowed O Other		
Number of Children:	Spouse's Name:	

EMERGENCY CONTACT AND REFERRAL INFORMATION

Name:	
Phone:	Relation to You:
Referring Physician:	SSN (for VA patients):
Referring Patient:	Are you working with an Attorney: O Yes O No
How Did you Hear About Us? O Word of Mouth O Advertisement O Social Media O Direct Marketing O Internet	

REASON FOR VISIT

What is the date of your scheduled appointment? ____/____/_____

How long have you had this complaint? O Less than 5 days (Acute) O 5-30 days (Sub Acute) O More than 30 days (Chronic)

What caused this condition?

What is the date this 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.

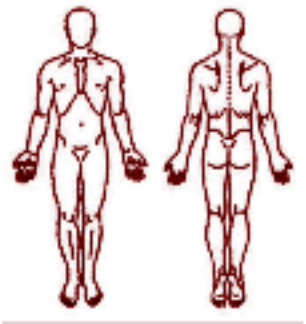
P – Pain,

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? O Constant O Frequent O Occasional O Intermittent

REASON FOR VISIT cont.

How has this complaint changed since the onset? O Worsened O Remained the same O Improved

What activity is most significantly affected by this discomfort? (Explain)

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?

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? O No O Yes Explain:

Are there any past illnesses or conditions we should be aware of?

O No O Yes Explain:

Do you have a past history of accidents or trauma?

O No O Yes Explain:

Are you presently taking any medications? O No O Yes Explain:

Do you have a past family illness history such as diabetes, cancer, hypertension, or progressive neurological diseases that we should be aware of? O No O Yes Explain:

WORK AND SOCIAL HABITS

Occupation: _____

Current work habits, select all that apply: O Permanently fully disabled O Permanently partially disabled

O Cannot work due to current condition O Full-time (20-40+ hours/week O Part-time (1-19 hours/week)

O Retired O Student O Homemaker O Unemployed O Self-employed

Personal social habits, select all that apply: O Smoke or use tobacco products O Drink alcohol O Drink caffeine

O Use recreational drugs O Other, to be discussed with doctor

Present exercise habits, select all that apply: O No current exercise O Exercise daily O Exercise 3+ times per week

O Cannot return to exercise due to current condition

Diet and nutritional habits, select all that apply: O Vegan or vegetarian O Gluten Free O Lactose Intolerant O Daily supplements

INFORMED CONSENT TO TREATMENT

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.

Patient Signature: _	Date: