FUNCTIONAL MOVEMENT
CHIROPRACTIC

Functional Movement Chiropractic, PLLC
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214-600-4336

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our Patient Intake Form. Please fill out this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Personal Information

*First Name: ____________________
Middle Name: ____________________
*Last Name: ____________________
Gender: ◯ Male ◯ Female
Date of Birth: ____________________
Social Security #: ____________________
Height: ____________________
Weight: ____________________
Marital Status: ____________________
Spouse's Name: ____________________
# of Children: ____________________

Emergency Contact: ____________________
Relationship: ____________________
Phone: ____________________

Contact Information

*email: ____________________
(We will NOT share with 3rd Party)

Home Phone: ____________________
Cell Phone: ____________________
Work Phone: ____________________

Address: ____________________
City: ____________________
State: ____________________
Zip: ____________________

Employment Information

Employer Name: ____________________
Employer Address: ____________________
Employer City: ____________________
Employer State: ____________________
Employer Zip: ____________________
Occupation: ____________________
Describe a normal work day: ____________________

What is the Purpose of your Visit? (If for Wellness care, then you may skip the next section.)

◯ Wellness ◯ Complaint ◯ Injury ◯ Other

Current Concern

When did you first notice? ______________________________

Do you know what may have caused the injury/discomfort to occur? ***(Please be as specific as you can)***

◯ Sports ◯ Fall ◯ Chronic Pain ◯ Home Injury

◯ Auto ◯ Work Injury ◯ Other ◯ I do NOT know

Explain: ______________________________

____

Was the pain/discomfort immediate or did it come on gradually over a period of hours/days/weeks?

____

____

List anything that AGGRAVATES your pain/discomfort: ______________________________

____

List anything that RELIEVES or IMPROVES your pain/discomfort: ______________________________

____

How would you describe the QUALITY of your pain/discomfort? (example: dull/aching, sharp/stabbing, etc)

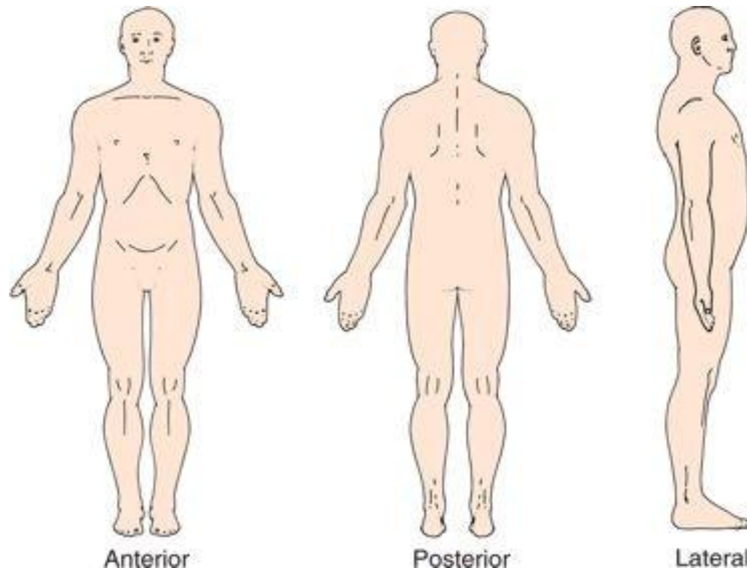
____

____

Does the pain RADIATE to any other area of your body?

◯ No ◯Yes If yes describe: ______________________________

Where do you feel the pain/discomfort? (indicate by circling the area of concern)



On a scale of 1 to 10 (1 being NO pain and 10 being the WORST pain of your life) how would you rate your pain/discomfort currently? (circle the number that best describes you)

1 2 3 4 5 6 7 8 9 10

Select frequency you experience pain from this concern:
◯ Always ◯ Hourly ◯ Daily ◯ Occasionally

Does this concern interfere with any of your activities of daily living or routines?
◯ No ◯Yes

Has this concern affected your quality of sleep or ability to sleep?
◯ No ◯Yes

Has this concern affected your appetite?
◯ No ◯Yes

If Yes to any of the above, Explain:
____
____
____

Since onset, has this concern:
◯ Become Worse ◯ Stayed the Same ◯ Become Better

Have you missed any work due to this concern?
◯ No ◯Yes

If yes, dates missed: __________
____

Have you reduced or limited your work hours because of this concern?
◯ No ◯Yes

If Yes, Explain:
____
____

Is the pain/discomfort worse at certain times of the day?
◯ No ◯Yes
If Yes, Explain: ______________________________
____

Do you believe your concern is causing HEADACHES?
◯ No ◯Yes

Do you suffer from HEADACHES regularly?
◯ No ◯Yes

Briefly Explain: ______________________________
____

Have you had this injury/discomfort before?
◯ No ◯Yes
Briefly Explain: ______________________________
____

If this has occurred before, then did you receive professional treatment for this?
◯ No ◯Yes

If Yes, Explain: ______________________

____

Have you seen another healthcare provider for this concern?

◯ No ◯ Yes

Name of Provider: ______________________

Type of Treatment: ______________________

Results: ◯ Good ◯ Bad ◯ Indifferent

Have you had X-RAYS taken for this concern?

◯ No ◯ Yes

If yes, Where? ______________________

Please list any health conditions that you have been treated for in the last year:

(condition, cause, current/resolved)

1.	4.
2.	5.
3.	6.

List current medications:

(name, amounts, frequency, length of use, reason for use)

1.	4.
2.	5.
3.	6.

Has any member of your family ever seen a chiropractor?

◯ No ◯ Yes

For Women Only

Are you pregnant? ◯ No ◯ Yes

Do you planning to be pregnant in the next 12 months? ◯ No ◯ Yes

Are you taking birth control? ◯ No ◯ Yes

Do you have irregular cycles? ◯ No ◯ Yes

Do you have painful periods? ◯ No ◯ Yes

Are you nursing? ◯ No ◯ Yes

Do you have breast implants? ◯ No ◯ Yes

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care plan. Please check the type of care desired so that we may be guided by your wishes whenever possible.

◯ **I want the Doctor to select the type of care appropriate for my condition.**

◯ **Relief Care:** Symptomatic relief of pain or discomfort.
◯ **Corrective Care:** Correcting and relieving the cause of the problem, as well as the symptom.
◯ **Comprehensive:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Authorization

I certify that I am 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 am 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 agree with this statement of authorization**

Name of the Patient: ______________________________
(please print)

Patient's/Guardian's signature: ______________________________ Date: ______________

Insurance & Payment for Care

How do you plan to pay for care?

◯ Self-Pay, submit for insurance repayment on own

NOT currently available with our Office, but please complete information as it will help with verifying your coverage for self-reimbursement.

◯ Personal Insurance ◯ 3rd Party Insurance

Name of Party Responsible for Payment: ________________

Responsible Party Phone: ________________

Primary Insurance

Insurance Name: ________________

Phone: ________________

Address: ________________

City: ________________

State: ________________

Zip: ________________

ID/Policy #: ________________

Group #: ________________

Insured's Name: ________________

Insured's DOB: ________________

If an auto accident, please provide:

Claim #: ________________

Insurance Contact Person: ________________

Insurance Phone: ________________

Attorney's Full Name: ________________

Attorney's Phone: ________________