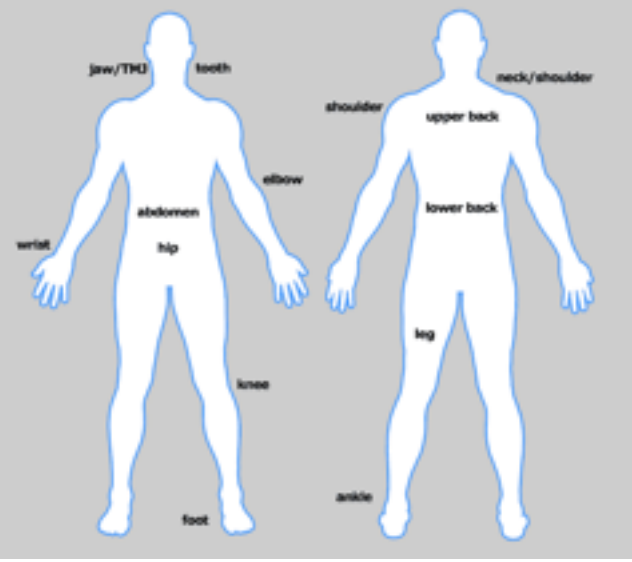
NEW PATIENT INTAKE FORM

	TODAY'S DATE:	☐ MALE	☐ FEMALE
NAME:	DATE OF BIRTH:	AGE:	CONTACT PHONE#:
ADDRESS:	CITY:	STATE:	ZIP:
EMAIL:	OCCUPATION/JOB TITLE:	TYPE OF WORK:	
HOW DID YOU HEAR ABOUT US?			
EMERGENCY CONTACT:		PHONE #:	

CURRENT HEALTH ASSESSMENT



PLEASE CIRCLE THE AREA OF MOST DISCOMFORT/PAIN THAT YOU WOULD LIKE OUR DOCTOR TO FOCUS ON TODAY.

*YOUR INITIAL VISIT TODAY WILL BE FOCUSED ON THE **ONE** AREA OF YOUR BODY THAT IS CAUSING THE MOST PAIN AND DISCOMFORT SO THAT WE CAN BEGIN THE PROCESS OF RESTORING YOU TO OPTIMUM HEALTH AND WELLNESS. PLEASE LIST AND DESCRIBE THAT BELOW:*

BODY AREA INVOLVED:	☐NECK (CERVICAL)	☐LOW BACK (LUMBAR)	☐MIDBACK (THORACIC)
	☐SHOULDER	☐ ELBOW	☐OTHER (FOOT, WRIST, HAND ETC)
CONDITION:	☐NEW		☐EXACERBATION
	☐RECURRING		☐CHRONIC

MECHANISM OF ONSET:	□AUTO □WORK	□LIFTING □OTHER	□OVER EXERTION	□REPETITIVE MOTION	□UNKNOWN □SLEPT WRONG	□SLIP OR FALL □NO INJURY					
SYMPTOMS:	□PAIN	□STIFFNESS	□NUMBNESS	□WEAKNESS							
LOCATION:	□LEFT	□RIGHT	□BILATERAL	□LEFT >RIGHT	□RIGHT >LEFT						
QUALITY:	□BURNING □RADIATING	□DULL □LOCALIZED	□SHARP □SHOOTING	□STABBING □THROBBING	□TIGHTNESS □TINGLING	□ACHY □OTHER					
IF RADIATING, PLEASE DESCRIBE (FROM/TO):											
ON A SCALE OF 1-10 (10- WORST) RATE YOUR SYMPTOMS	0	1	2	3	4	5	6	7	8	9	10
WHEN DID YOUR SYMPTONS START?											
HAVE SYMPTONS WORSENED SINCE THEY BEGAN?											
WHEN DID THE SYMPTONS LAST OCCUR?											
SYMPTOMS WORSE IN THE:	□MORNING □CONSTANT	□AFTERNOON	□NIGHT								
DO YOU SUFFER FROM HEADACHES? IF SO, PLEASE DESCRIBE:	□ NO □ SHARP	□THROBBING □STABBING	□AURA □DULL								
MODIFYING FACTORS, SYMPTOMS **IMPROVE** WITH:	□ACTIVITY □BENDING □COLD	□HEAT □MASSAGE □MOVEMENT	□OTC MEDS □RX MEDS	□REST □STRETCHING	□SITTING □STANDING	□TWISTING □WALKING	□NOTHING HELPS				
MODIFYING FACTORS, SYMPTOMS **WORSEN** WITH:	□ACTIVITY □BENDING	□COLD □HEAT	□SITTING □MOVEMENT	□STANDING □WALKING	□TWISTING □STRETCHING						
SINCE CONDITION BEGAN, HAS ANYTHING TEMPORARILY HELPED ALLEVIATE SYMPTOMS?	□YES □NO	IF SO, PLEASE DESCRIBE IT HERE:									
IF YOU HAVE EVER HAD ANY SURGERIES PLEASE LIST:											

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? OTC OR PRESCRIPTIONS?	□YES	□NO	IF SO PLEASE LIST:

PLEASE READ CAREFULLY AND SIGN BELOW		
I understand and agree that AIM Health and Chiropractic is a "fee for service" clinic and does not accept insurance for services provided. Payment for service is due and payable at the completion of service via cash, check or debit/credit card. I also expressly agree that AIM Health and Chiropractic, its employees, owners and officers shall have no liability relative to the treatments prescribed and performed and their results or improvement in my condition is not guaranteed. I agree to and authorize treatment by AIM Health and Chiropractic and Dr. Tesha A. McCall and that I agree that I am solely responsible for payment on my account.		
PATIENT (PRINT NAME):	SIGNATURE:	DATE:

Auto Accident Patients: If your visit to AIM Health and Chiropractic today is due to an auto accident, please let our front desk know as there is additional paperwork specific to your injury/incident that we will need to have you fill out. When returning this paperwork to the front desk, please provide your Driver's License so that we can make a copy and include in your patient file. ***Thank you and welcome to the AIM patient family!***