BOVA
FAMILY CHIROPRACTIC

New Client Intake Form

Name_____Age ____ DOB____/____/____ Male □ Female □

Address_____City_____State_____ Zip_____

Home Phone_____ Cell_____ Email_____

Employer_____ Occupation_____

Name of Spouse_____ Spouse's Employer_____

Names & Ages of Children_____

Name and Number of Emergency Contact_____

Whom may we thank for referring you to this office?_____

CASE HISTORY

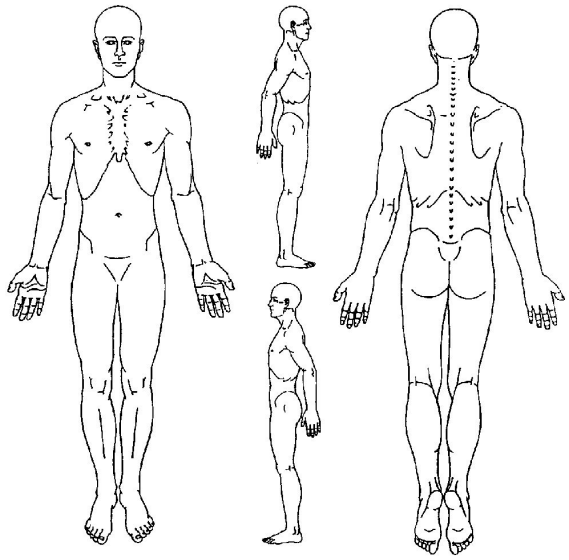
Please identify the condition(s) that brought you to this office:

Primary:_____Second:_____

Third:_____Fourth:_____

Rate the severity of the above complaint(s) on a scale of 0-10:

Primary:	0	1	2	3	4	5	6	7	8	9	10
Second:	0	1	2	3	4	5	6	7	8	9	10
Third:	0	1	2	3	4	5	6	7	8	9	10
Fourth:	0	1	2	3	4	5	6	7	8	9	10



*Fill in <u>all</u> areas of discomfort on the figure to the right by using

the following letters: **A** – aching **B** – burning **D** – dull

N – numbness **R** – radiating **S** – sharp **T** – tingling

When did this problem begin?_____Has it ever occurred before? □ Yes □ No

The problem is worse in: □ AM □ PM □ At Night □ With Activity (bending, lifting, sitting, standing)

Frequency of complaint is: □ Constant □ On/off during day □ Comes and goes throughout the week

Is condition related to? □ Auto Accident □ Work Injury □ No Injury □ Other

Has this condition ever been treated by anyone in the past? □ No □ Yes, Dr._____Date

How long were you under care?_____ What were the results?_____

What makes you feel better?_____ What makes you feel worse?_____

Have you ever received chiropractic care? □ No □ Yes, Dr. Name_____Date of last visit_____

DAILY ACTIVITIES	What kind of effect does your condition have on the following? Check all that apply.			
Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bending	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dancing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Exercising	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Gardening	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Reading	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Recreational Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting / Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Watching TV	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Please label the lines below by using the following letters: **C** – current **P** – past (over 6 months ago) **N** – never

__ADD/ADHD	__Allergies	__Anxiety	__Asthma	__Bed Wetting
__Blurred Vision	__Cancer	__Chest Pain	__Circulation	__Colon Trouble
__Convulsions	__Depression	__Digestion	__Dizziness	__Double Vision
__Ear / Hearing	__Eating Disorder	__Fainting	__Flu/frequent colds	__Gall Bladder
__Headache	__Heartburn	__Heart Problem	__Hepatitis (A, B, C)	__Hormone
__Impotence	__Irritability / Mood	__Jaw pain / TMJ	__Kidney Problem	__Liver Problem
__Loss of Balance	__Low Energy	__Lung Problem	__Muscle Spasm	__Nausea/Vomiting
__Nose Bleed	__Rash / Skin	__Scoliosis	__Sinus	__Sleep
__Swollen Joint	__Tremors	__Thyroid	__Ulcers	__Weight Gain/Loss

FEMALES ONLY:	__Irregular Period	__Painful Period	__No Period	__Hot Flashes
Are you pregnant?	__ Yes __ No	__ Not Sure		

List all medications currently used:

Provide reason for use and length of time on medication:

_____ _____

_____ _____

_____ _____

_____ _____

Check surgeries or procedures that apply. □ I have never had any surgeries or procedures.

□ Appendix	□ C-Section	□ Chemotherapy	□ Gall Bladder	□ Heart
□ Hernia	□ Reproductive	□ Spine	□ Thyroid	□ Vaccinations

Other_____

List any conditions or diseases not previously mentioned_____

RESTRICTED ACTIVITIES	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
1._____:	_____	
2._____:	_____	
3._____:	_____	

Rate your stress level on a scale of 0-10:_____Cause of stress_____

Describe sleep patterns:_____List any hobbies_____

Alcohol drinks/day_____
Coffee cups/day_____
Smoking cigarettes/day_____
Water cups/day_____

EXERCISE
□ None
□ 3-4 times/week
□ Daily

FAMILY HISTORY	Spine	Cancer	Diabetes	Heart
Mother	□	□	□	□
Father	□	□	□	□
Siblings	□	□	□	□

Goals for Your Care:
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 care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

On a scale of 1 to 10 with 10 being the highest, rate your commitment to getting rid of the problem:_____

Please specify any concerns that could interfere with your commitment (example: time, transportation, other)

_____

Were You Aware That…
Doctors of Chiropractic work with the nervous system?
No__ Yes__
The nervous system controls all bodily functions and systems?
No__ Yes__
Chiropractic is the largest natural healing profession in the world?
No__ Yes__

Do you have Health Insurance? □ No □ Yes (please complete the box below)

Insured's Name_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Policy Number_____

If I am covered by health insurance, I understand and agree that health insurance policies are an arrangement between my insurance carrier and me. Whether I do or do not have insurance, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if insurance is applied I am responsible for any amount not covered or paid by my insurance (deductibles, copayments, denials, etc.) I acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Bova Family Chiropractic for any and all services I receive. We also reserve the right to bill any balance due past 30 days to your credit card on file.

Patient Signature_____Date Completed_____

Doctor Signature_____Date Reviewed_____