Welcome to Pitts Family Chiropractic

Patient Intake Form (New / Update)

Date ____ / _____ / ______

(circle one): Mr. Mrs. Ms. Miss. Dr. Prof. Rev.

First Name: __________________________ Middle: _______________

Last Name: ____ SSN:____________________________

What do you like to be called: __________________________________

Gender: **(circle one)**: M F Date of Birth: ____/____/_____ Height: _____/______ Weight: __________

Address: ____

City: ___________________________________ State: _______________________ Zip Code: _____________

Cell #: ___________________________ Text reminder: Yes No Home #: ______________________________

Email: ____

Employer's Name: ___________________________________ Employer's Phone: ________________________

Occupation: ____

In case of an emergency whom would you like us to contact? ____________________________________

Relation: _____________________ Phone: ______________________________

Who is your medical doctor? ____

Employment Status: **(circle one)** Employed Student Self Employed Retired Other

Marital Status: **(circle one)** Single Married Widow/Widower Other

Race: **(circle one)** White Black/African American Hispanic American Indian Other I choose not to specify

Multi-Racial: **(circle one)** Yes No Unknown

Ethnicity: **(circle one)** Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: **(circle one)** English Spanish Other I choose not to specify

Are you a smoker? **(circle one)** Yes No

If yes, how often do you smoke? **(circle one)** Current every day smoker Current sometime smoker

Are you a former smoker? **(circle one)** Yes No

How often do you exercise? ____

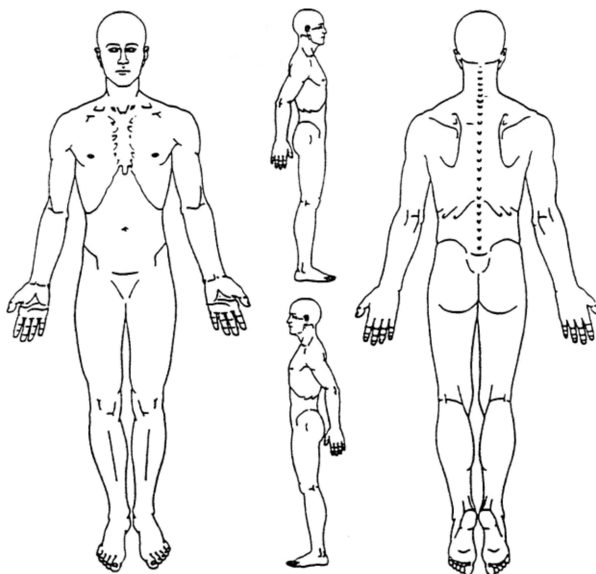
Social Habits? (alcohol, caffeine, recreational drugs, etc) ___________________________________

Do you have a pacemaker or electric implants? **(circle one)** Yes No

For Women Only: Are you pregnant? **(circle one)** Yes No If so, due date: _______________

Reason for Visit

Please mark an X on the areas you have pain or other symptoms:



Describe your current problem and how it began:

Is this? **(circle one)**: Work Related Auto Related N/A

Date problem began: ____

How problem began: ____

Please describe your pain: ____

Constant 76-100% Frequent 51%-75% Intermittent 26-50% On & Off Less than 26%

What is the quality of discomfort **(circle all that apply)**: Aching Annoying Burning Deep

Heavy Intolerable Pulling Spasms Sharp Shock like Stabbing

Stiffness Dull Throbbing Tightness Tingling Numbness Other

Have you seen any other specialists for this condition? **(circle one)** Yes No

Have you had any surgeries, falls, or accidents? **(circle one)** Yes No

When? Please describe: ____

Briefly list your main health problems: ____

Do you have a family history with any of the following **(circle all that apply)**:

Diabetes Rheumatoid Arthritis Back problems Cancer Tuberculosis

Heart attacks Hypertension Other:___________________

Allergies/Medications: ____

Do you have medical health insurance? **(circle one)** Yes No

Health Insurance: ____________________________ Member ID: _____________________

Insured's Name *(if other than self):* _____________________________________ Date of Birth: ___/___/___

Insured's Employer: ___________________________ (*Please inform front desk if you have a 2nd insurance)*

Who may we thank for referring you to our office: ____

- Our Policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the provider. If account balance has not been paid within 90 days of the date of service and no financial arrangements have been made, you will solely be financially responsible for any expenses incurred in collecting your account. We may send your account to our collections company, MJ Altman if after 5 months of no payment or arrangements have been broken with our financial department.

- I hereby state that all information that I have given to Pitts Family Chiropractic is complete and truthful. I will not misrepresent the severity or cause of my health concern. I further state that I have disclosed my full health history. I present myself for health reasons only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner. I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me by licensed doctors of chiropractic who may now or in the future treat me while employed at Pitts Family Chiropractic. I acknowledge that results are not guaranteed or assured. I understand that I will have an opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that as in the practice of medicine, the practice of chiropractic has some risks to treatment including but not limited to: muscle strains and sprains, disc injuries, fractures, strokes, and dislocations. I do not expect the doctor to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon all factors then known is in my best interests.

- I authorize Pitts Family Chiropractic to release any information required to process insurance claims. (If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you are at the front desk).
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____

Print

____ _____ / _____ / _____

Sign **Date**

If the patient is a minor (under 18 years old) Parent or Guardian must print and sign below

____

Print

____ _____/_____/_____

Sign **Date**

801 Northeast 25th Avenue
Ocala, Fl. 34470

Phone: (352) 732-0200
Fax: (352) 732-2623

Pitts Family Chiropractic

Dr. Sonja J. Lonadier

Dr. Travis R. Wilemon

Dr. Jeanna L. Taylor

Dr. Katherine White

Dr. James Garemore

Authorization to release Healthcare Information

Patient's Name: ____ Date of Birth: ___ / ___ / ___

Previous Name: _______________________________________ Social Security # ____________

___ I am requesting a copy of my records

OR

I request and authorize ____ to

release healthcare information of the patient name above to:

Pitts Family Chiropractic

801 NE 25th Avenue

Ocala, Fl. 34470

This request and authorization applies to:

___ Healthcare information relating to the following treatment, condition or dates:
____

___ All healthcare information

___ Other: ____

____ Date: ____ / ____ / ___

Sign