Gulf Coast Sport & Spine, LLC

New Patient Intake Form

Title: (Check one) ☐Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

First Name ___________________ **Middle Initial** ____ **Last Name** __________________________

Address ____

City _______________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-___________ **Work Phone** (_____) _________-____________

Cell Phone (_____) ________-___________ **Email** ___________________________________
(leave blank to opt-out of emails)

Date of Birth ______/______/_______ **Sex:** ☐ Male ☐ Female

Social Security Number: ______-_____-______ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other_________

Employer Data

Employer ____

Your Occupation ____

Spouse Data

Is your spouse a patient in this clinic? ☐Yes ☐ No

First Name ________________________ **Middle Initial** ____ **Last Name** _____________________

Home Phone (_____) _______-__________ **Work Phone** (_____) _______-____________

Spouse Date of Birth _____/_____/_______

Emergency Contact

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone** (_____) ________-______________

How did you hear about our office? ____

3941 Houma Blvd. Ste 2A, Metairie, LA 70006 (504)-372-4062

GULF COAST SPORT & SPINE, LLC

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Breast Augmentation	☐ Other ______________		

*****Please provide date and specific procedure if applicable:** __________________________________

____

Allergies: (Check all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk/Lactose	☐ Animal
☐ Egg	☐ Sulfites	☐ Wheat/Glutens	☐ Peanut
☐ Soy	☐ Fish/Shellfish	☐ Chemical ________	☐ Other _________

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Drink Water:	☐ <64 oz/day	☐ >64 oz/day	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Sleep:	☐ <8 hours/night	☐ >=8 hours/night	☐ Insomnia

Other ________________

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other _________________

Occupational Activities: (Check all that apply)

☐ Administration	☐ Business owner	☐ Clerical/secretarial	☐ Computer user
☐ Construction	☐ Daycare/childcare	☐ Executive/legal	☐ Food service industry
☐ Health care	☐ Heavy equipment operator	☐ Heavy manual labor	☐ Home services
☐ Household	☐ Light manual labor	☐ Manufacturing	☐ Medium manual labor

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Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Additional Medical Conditions: (Check all that apply to you)

☐ Fibromyalgia ☐ Rheumatoid Arthritis ☐ Multiple Sclerosis ☐ Lupus ☐ Other ___________

Please list all current medications being taken ____

____

Do you take daily vitamins/supplements? ☐ Yes ☐ No

Are you satisfied with the quality of the vitamins/supplements you take? ☐ Yes ☐ No ☐ N/A

Are You Pregnant? Yes No - If yes, how many weeks pregnant are you? ___________

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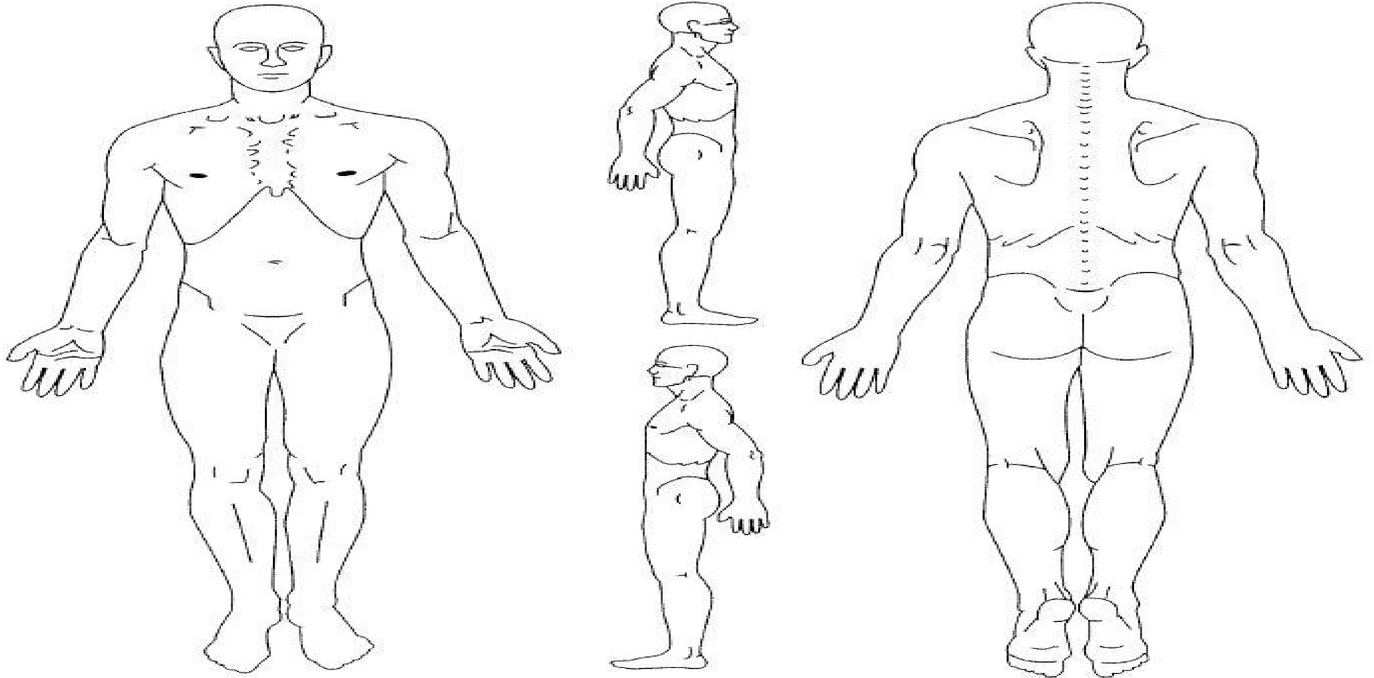
By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Please list anything that relieves the pain: ____

Please list anything that worsens the pain: ____

When did your symptoms begin? ____

How did your symptoms begin? ____

____

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Throbbing
- ☐ Other_____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

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During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time
☐ None of the time

In general, would you say your overall health right now is….

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms:

☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
☐ Other ___________________

What treatment did you receive for your symptoms?

☐ Adjustments ☐ Physical Therapy ☐ Medication ☐ Surgery
☐ Other ____________________

When did you receive this treatment?

☐ In the last month ☐ 2 – 3 months ago ☐ 3 – 6 months ago ☐ 6 months to 1 year ago
☐ 1 – 2 years ago ☐ 2 – 5 years ago ☐ 5 – 10 years ago

What tests have you had for your symptoms?

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG/NCV ☐ Other

When were these tests done?

☐ In the last month ☐ 2 – 3 months ago ☐ 3 – 6 months ago ☐ 6 months to 1 year ago
☐ 1 - 2 years ago ☐ 2 – 5 years ago ☐ 5 – 10 years ago

Have you had similar symptoms in the past?

☐ Yes ☐ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
☐ Other ________________________

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PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Patient's Signature ____Date______________

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient's Signature____Date_____________

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility or the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. You Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a physician at Gulf Coast Sport and Spine, LLC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature____Date:_____________

PLEASE TURN INTO FRONT DESK

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