New Patient Intake Form
North Bridge Chiropractic
Integrated Wellness
Dr. Ellen M. Lazar, D.C.

42000 Six Mile Rd.
Suite 230
Northville, MI 48168
(248) 924-2413

Hello! Please fill out the following as complete as possible. Signatures and dates are EXTREMELY important. This is part of your Electronic Health Record **(EHR)** required by the U.S. Government's **CMS** (Centers for Medicare Services). If you have any questions **OR choose to NOT do so**, feel free to call us and we will help! If you do not wish to fill this form out, **please speak to me in person. – Dr. Ellen M. Lazar, D.C.** The more you complete now, the quicker we can help you when you arrive.

Patient Information

Last, First, Middle: _____ **Gender**: ○ Female ○ Male

Email: _____ (we will **NOT** voluntarily let our vendor or a third party have access to it)

Birthdate: _____ **Marital Status**: (circle one): Single Married Divorced Widow/Widower

Address: _____

Phone used to confirm appointments: (_____)_____ **Preference** : ○Phone ○Text ○E-mail

Emergency contact and phone number: (_____)_____

Preferred Language: _____(none chosen = English)

Smoking Status: MUST CIRCLE ONE

○**Current Every** ○**Current Some Day** ○**Ex-smoker** ○**Never Smoked** ○**Heavy Tobacco Smoker** ○**Light Tobacco Smoker**

I MUST REPORT TO CMS BOTH RACE and ETHNICITY if you do NOT, we MUST, based on our best estimate

RACE: ○American Indian **or** Alaska Native ○Asian ○Black/African American ○Native Hawaiian or Other Pacific ○White/Caucasian

ETHNICITY: ○Hispanic or Latino ○NOT Hispanic or Latino

CURRENT **PRESCRIPTION MEDICATION ONLY**: (use back of this form if you need more space)

Medication FULL NAME (accuracy IS important)	Dosage (if unknown, we will post the lowest on the EHR)

ALLERGIES TO PRESCRIPTION DRUGS or Anything else you may want to add (non-prescription allergies will NOT be posted in EHR):

Medication/Drug Name	Reaction (what happens?)	Date it happened/started

○ **Please check to decline the receipt of a clinical summary after every visit**. (These summaries are often blank as a result of the nature and frequency of chiropractic care. Your examination and treatment results will be reviewed on your follow-up visit, personally. **If you do not decline**, you must contact our office immediately and **re-schedule** your appointment during specific, restricted hours at which I may complete your summary before you leave the clinic.)

We will fill this part out for the **EHR** during your first visit:

Ht:	**Wt:**	**BP:**	**Pulse:**

*Signature: _____ Date: _____

*(there will be a few more signatures and dates required in your forms)

●Please tell us the reason of today's visit, as complete as possible: _____

_____

_____

History – Initial E&M

●**Where/What** is your CHIEF MAIN **WORST COMPLAINT**? (You will be given more places to add more complaints toward the end. We have to have a priority order to be able to address your most important one first, to best care for you.) _____

_____

_____

_____

●Does it **Radiate or Travel**? ○ **Yes** ○ **No** **Describe** this: _____

●Describe the **QUALITY** of the discomfort/pain (circle as many that apply)

Aching	Deep	Heavy	Sharp	Stabbing	Tightness
Annoying	Diffuse	Intolerable	Shock-like	Stiffness	Tingling
Burning	Dull	Pulling	Shooting	Throbbing	
Other (please add)					

●**What** was the **way/how** it happened? _____

_____

_____

●**Was the onset** (circle one):

Gradual	Insidious/Subtle	Recent	Spontaneous	Sudden	Traumatic	Unknown

●**Describe** the **intensity** of the discomfort (circle one):

Mild	Mild to moderate	Moderate	Moderate to severe	Severe

●Were you ever hospitalized for it? ○ **Yes** ○ **No** **When**? _____

●What was the **DATE** it started? _____ **How BAD** does it get on a scale of **1 to 10**, (10 is WORST POSSIBLE)? _____

●How **often** do you feel this discomfort? (circle one)

Constant 100%	Frequent 75-99%	Intermittent	On and Off	Random	Recurring

●**How has this complaint changed since it started**? (choose one)

Improved	Stayed the Same	Worsened	Describe other: _____

●The **activity(s)** of your **daily life** that it **most** affects/alters? Employment, homemaking, lifting, self-care (washing, dressing), sitting, sleeping, social life, standing, travelling and/or driving, walking, more…_____

●**Things that are difficult to do because of this**? (things you want to be better) Bending over, Caring for Family, Climbing Stairs, Concentrating, Dressing Self, Driving Car, Exercising, Getting in/out of Car, Getting to Sleep, Grocery Shopping, Performing Household Chores, Lifting Objects _____pounds, Looking over Shoulder (**choose: R or L, both**), Making Love, Lying Down, Reaching Overhead, Rising out of Chair or Bed, Showering or Bathing, Sitting, Standing, Staying Asleep, Using a Computer, Walking, Walking more than _____ feet, Walking more than _____ minutes, Participating in Yard Work, more _____

_____

_____

Please INITIAL: _____

●**Things that aggravate this condition**? Circle as many that apply and/or add your own in the box. Be as specific as possible.

Almost any move	Concentrating	Gettining out of bed	Love life	Resting	Stress	Working
Athletics/Exercise	Cooking	Getting up from lying down	Lying down	Running	Stretching	Yard work
Bathing	Cough / Sneeze	Getting up from sitting to stand	Pulling	Self-care (dress, baths, etc.)	Talking on telephone	Other
Bending	Daily child or pet care	Grocery shopping	Pushing	Shaving	Turning _____ (circle Rt or Lt)	
Caring for family	Driving	Household chores	Reaching	Sitting	Twisting	
Change positions	Eating	Lifting	Reading	Squatting	UNKNOWN	
Climb stairs	Falling asleep or staying asleep	Looking over shoulder (circle Rt or Lt)	Repetitive motions	Standing	Walking	
Computer use	Getting in or out of car					

●**What IMPROVES your worst complaint**? Circle all that apply.

Nothing	Heat packs	Prescription Medications	Work
Chiropractic Adjustments	Massage	Re-direct of attention	Other
Cold packs	Over counter medications	Rest	
Exercise	Physical Therapy	Stretch	

●**What treatment have you received for this up to now**?

None	Homeopathic medicine	Naturopathic medicine	Over the counter medications	Reiki
Acupuncture	Hypnosis	Nutritional supplements	Physical therapy	Surgery
Chiropractic Care	Injections therapy	Occupational therapy	Prescription medications	Yoga
Craniosacral Therapy	Medical care	Osteopathic medicine	Psychotherapy	Other (use space below)

●Were there any Diagnostic tests performed to assess this condition (X-rays, MRIs, CT scans, etc.)? Yes or No

Where were they performed? _____

When? _____

●Have you ever had any previous episodes of this condition? ○ Yes or ○ No

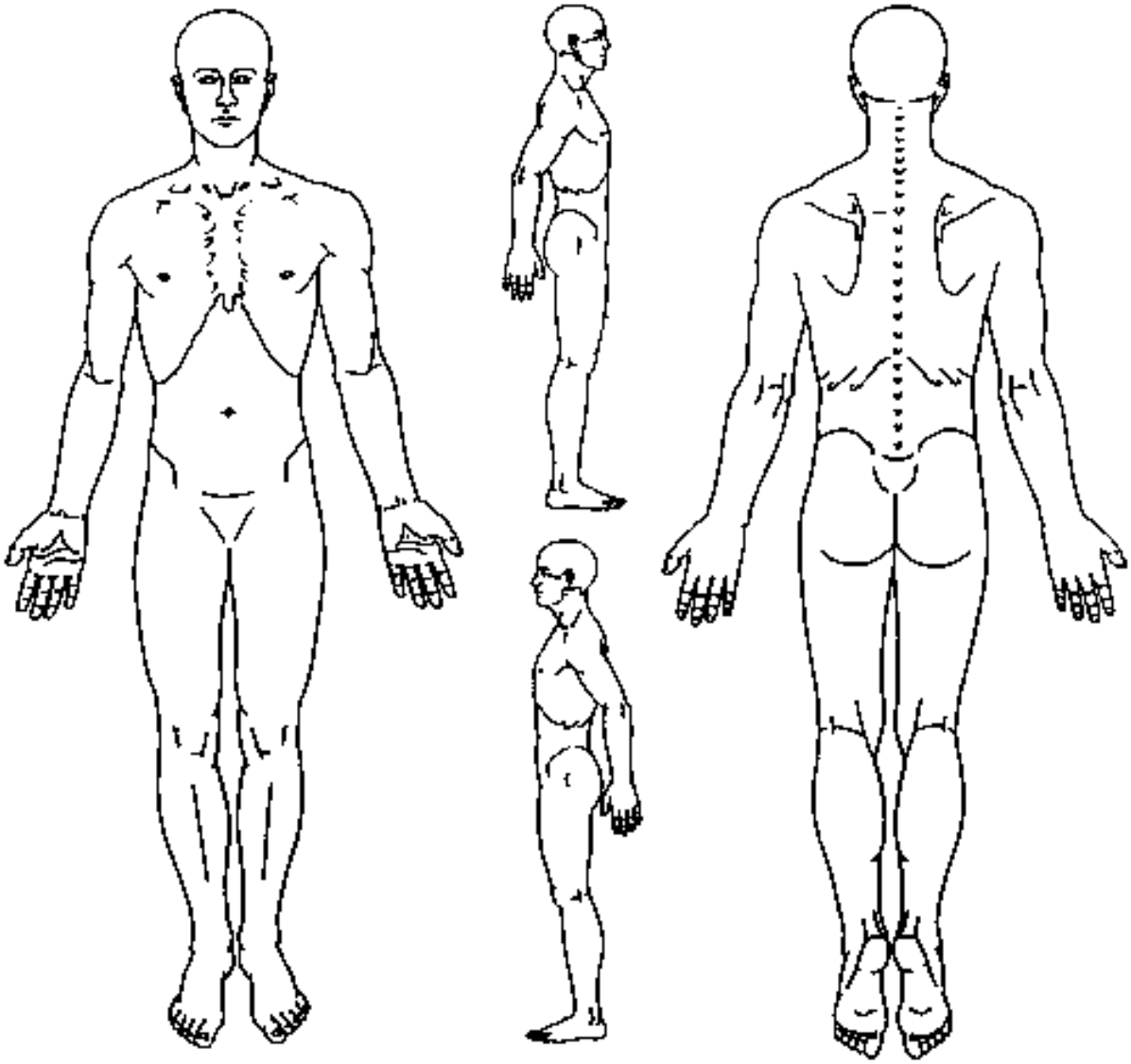
●**In what ways does this condition affect your life and your ability to function? Circle all that apply.**

Bending over
Caring for family
Climbing stairs
Concentrating
Dressing myself
Driving a car
Exercising
Getting in/out of car
Getting to Sleep
Grocery Shopping
Household chores
Lifting objects
Looking over shoulder (pick RIGHT or LEFT or BOTH)
Love life
Lying down
Reaching overhead
Rising out of chair or bed
Showering or bathing
Sitting more than _____
Standing more than _____
Staying asleep
Using a computer
Walking
Yard work

Please INITIAL: _____

Add your own story. The more specific, the better. These are goals to reach for your insurance carrier to understand your need for care better.

Draw or Label Your Symptoms



Add/write anything else you want to here:

_____

_____

_____

_____

_____

_____

Please INITIAL: _____

Review of Systems (Write as much as you want next to an area. Use the back of the pages if you want.)

Musculoskeletal complaints/problems ○ No additional musculoskeletal complaints

Neurological complaints/problems – nerve, loss of feeling, function, abilities ○ No additional neurological complaints

Head, Eyes, Ears, Nose and Throat complaints/problems ○ No head, eye, ear, nose or throat complaints

Cardiovascular complaints/problems – heart, blood vessel ○ No heart or blood vessel complaints

Respiratory complaints/problems – breathing, lungs ○ No breathing complaints

Gastrointestinal Stomach or intestinal complaints ○ No stomach or intestinal complaints

Genitourinary Genital or bladder or urinary or sexual complaints ○ No genital or bladder or urinary or sexual complaints

Endocrine Hormone or glandular concerns/problems ○ No hormone or glandular complaints

Dermatological and Bleeding Skin or bleeding concerns ○ No skin or bleeding complaints

Date of Last Physical Exam: _____ **Primary Physician:** _____
Other Physicians: _____
Please list any other health conditions that you have been treated for in the past few years

Have you had chiropractic care before? ○ **Yes** or ○ **No** When was the LAST time you went and got adjusted? _____

Tell us what you DON'T like about getting adjusted (your neck, too hard, too gentle) _____

Please INITIAL: _____

Goals for Your Care (pick one and feel free to write additional information)

○ Relief Care (Symptomatic relief of pain or discomfort.)
○ Corrective Care (Correcting and relieving the cause of the problem as well as symptoms.)
○ Comprehensive Care (Bring whatever is malfunctioning in the body to the highest health state possible using various methods employed by our practice.)
○ Other (Please be specific)
○ Nutrition

_____
_____
_____

Are you PREGNANT or think you may be? ○ Yes or ○ No
Are you planning to get pregnant in the next 12 months? ○ Yes or ○ No

●List your **current** *vitamins, minerals, supplements, herbs or homeopathies* OTHER THAN PRESCRIPTIONS

_____
_____
_____
_____

●Kindly remind us of who referred you to our clinic or how you heard about us so we may properly thank them:

_____

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. Nutritional supplements, vitamins, herbals and other goods recommended for your care are not billable to any insurance company and must be paid for at the time of service. 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 that fees for professional services will become immediately due upon suspension or termination of my care or treatment. It is my responsibility to notify the doctor and staff of ANY insurance changes immediately BEFORE receiving care or treatment.

* ☐ I agree with this statement of authorization

Name of the Insured/Patient (PRINT)_____

SIGNATURE of Insured/Patient ✕_____

FOR MINORS:

Legal Guardian's Name (PRINT)_____
Proof of Guardianship must be presented to staff and a copy maintained BEFORE care/examination is rendered
Guardian's SIGNATURE (if applicable) ×_____