Dr. Andrew Riddle
Dr. Kelly Keener
Dr. Lauren Hitchens
Dr. Gary Morgan

Phone: (302) 422-3100
Fax: (302) 422-2900
AtlanticChiropractic.net

ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.

Gentle, Effective Care for All Ages

New Patient Intake

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (check one) **Gender:** ☐ Male ☐ Female **Date**: _______ /_________/_________

First Name: ____________________________ Middle Initial: _______ Last Name: _________________________________

Address: ____

City: ____ State: __________________ Zip Code: ___________________

Home Phone: (________) _________-_____________ Work Phone: (________) ___________-___________

Cell Phone: (________) _________-_________ Preferred contact method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Date of Birth: _______/_______/__________ Age: ________ Email:____

Primary Doctor: _______________________________ City:______________________________ State:___________________

Race: (check one)
☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Other_____________ ☐ I choose not to specify

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: (check one)
☐ English ☐ Spanish ☐ Other___________________ ☐ I choose not to specify

Marital Status: ☐ Single ☐ Married ☐ Other_____________________ Is your spouse a patient in the clinic? ☐Yes ☐ No

Spouse Data:
First Name: ______________________________ Middle: _____ Last Name: ____

Home Phone: (______) _________-__________ Cell Phone: (______) _________-_________________

Patient Employer Data:
Employment Status: ☐ Employed ☐ FT/ ☐ PT ☐ Student ☐ FT/ ☐ PT ☐ Retired ☐ Homemaker ☐ Unemployed

Employer Name: ____

Address Line: ____ City: ____________________________ State:__________

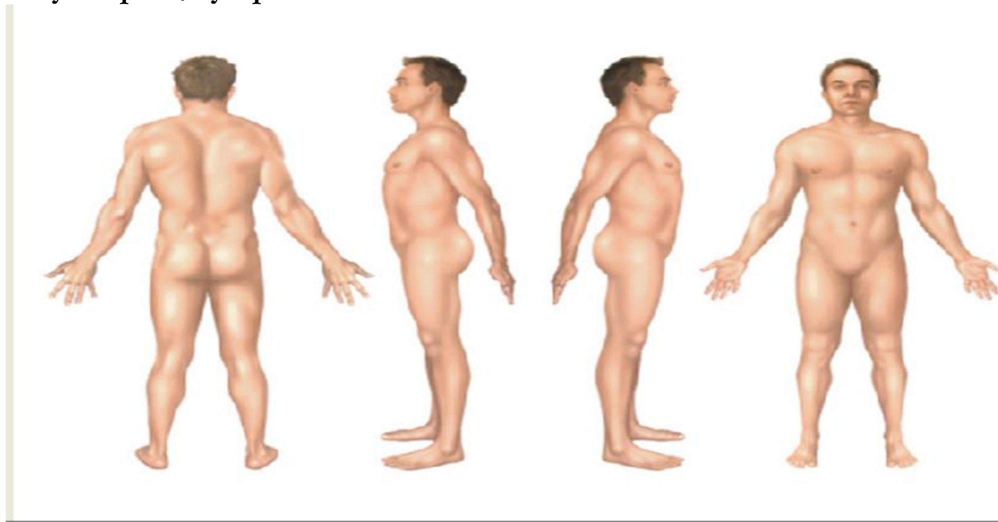
Job Title/Position:____

Emergency Contact:
Contact Name: ____ Relationship:_____________________________________

Phone:(________)_________-_____________

Current Complaints:

Please mark where your pain/symptoms are:



Please grade your pain on a scale of 0-10:
[0= No Pain, 10= Extreme Pain]

Choose how frequent the pain is present:

Neck:	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**
Upper/Mid Back:	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**
Lower Back:	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**
______________	**0 1 2 3 4 5 6 7 8 9 10**	**Seldom - Intermittent - Frequent - Constant**

Area(s) of complaint:

1. ____________________ 3. ____________________
2. ____________________ 4.____________________

When did this episode begin/increase?

1. ____________________ 3. ____________________
2. ____________________ 4. ____________________

What do you believe is causing your symptoms?

1. ____________________ 3. ____________________
2.____________________ 4.____________________

Is your pain **worse/better/the same** in the **morning/throughout the day/in the evening/at night ?** Circle one from each group.

Circle which ones describe your symptoms:

- dull
- sharp
- throbbing
- burning
- deep
- aching
- tingling
- stabbing
- cramping
- numbness
- radiating
- stiffness

Other symptoms:____________________

Can you go to sleep without problems? ☐ Yes ☐ No
Do you awaken because of pain? ☐ Yes ☐ No
If yes, where is the pain that wakes you up? ____________________

To be performed by clinic staff: Height: _____ in Weight: _____ lbs BP:_____/______ Pulse:_____bpm

Patient Name:____________________
Patient #:____________________ **Date:**____________________

Circle the activities that aggravate your condition:

• sitting	• standing	• walking	• bending	• stooping	• lifting
• sleeping	• sneezing	• coughing	• straining	• reaching	• twisting
• looking up	• looking down	• movement	• rest	• lying face down	• driving
• typing	• scooping	• house chores	• exercise	• lying face up	• stair stepping

Other aggravating factors: ____________________

Circle activities that relieve your condition:

• sitting	• standing	• lying	• knees bent up	• support
• no movement	• movement	• heat	• ice	• topical gel
• ibuprofen	• medication	• rest	• stretching/exercising	• adjustments

Other relieving factors: ____________________

Any prior history of current complaints? ☐ Yes ☐ No
If yes, please describe episodes with dates: ____________________
____

Prior treatment by a chiropractor for these? ☐ Yes ☐ No If yes, please list who and when:
1.____________________
2.____________________

Have you had any recent imaging / testing? ☐ Yes ☐ No
If yes, please list type (Xray, MRI, CT, EMG, etc) location and date taken:
1.____________________ DATE: __________
2.____________________ DATE: __________

General Information:

Handedness: ☐ L ☐ R ☐ Both
Tobacco Use: ☐ Current Every Day Smoker ☐ Sometimes Smoker ☐ Former Smoker ☐ Never been a Smoker
What is your level of interest in quitting smoking?
☐ 0 (No Interest) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Very Interested)
Alcohol Use: ☐ None ☐Social ☐Moderate ☐Heavy
Have you ever been disability rated? ☐ Yes ☐ No If yes, for what? ____________________

Treatment History:

Any prior Doctor seen for this condition? ☐ Yes ☐ No
1. **Doctor Name:** ____________________ Specialty: ____________________
Date seen: ____________________ Referred by: ____________________
Treatment type: ____________________
Currently treating? ☐ Yes ☐ No Did treatment help you? ☐ Yes ☐ No
Referred to another Provider? ____________________
Notes:____________________
2. **Doctor Name:** ____________________ Specialty: ____________________
Date seen: ____________________ Referred by: ____________________
Treatment type: ____________________
Currently treating? ☐ Yes ☐ No Did treatment help you? ☐ Yes ☐ No
Referred to another Provider? ____________________

Patient Name:____________________
Patient #:____________________ **Date:**____________________

Current Medical History

Current Health Problems (Heart Disease, Diabetes, High Blood Pressure, etc): ☐ None

____

____

Current Medications Taken:

☐ Vitamins/Supplements ☐ None ☐ See Separate List

____

____

Are you currently pregnant? ☐ Yes ☐ No **If so, what is your due date?** ____________

Have you had children? ☐ Yes ☐ No **If so, how many children have you had?** ____________

List any known allergies you have had to any medications: ☐ No known allergies

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

Has any doctor ever diagnosed you with High Blood Pressure? ☐ Yes ☐ No

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No

If yes, what kind? ☐ Type 1 ☐ Type 2 If yes, was most recent hemoglobin A1c> 9.0%? ☐ Yes ☐ No ☐Not Sure

If yes, other comments regarding Diabetes: ______________________

Past Medical History:

Injuries to Head, Neck, or Back, including Motor Vehicle Accidents or Work Injuries:

____

____

Surgeries (*Include all, not just neck and back*). List **Date** and **Type**: ______________________

____

____

Fractures (*Include all, not just neck and back*) List **Date** and **Type**:______________________

____

Family History: Please circle and check all that apply

Diabetes	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Heart Disease	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
High Cholesterol	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Hypertension	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Osteoporosis	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Cancer (specify): __________	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Psychological Disorders	Yes	No	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son

☐ **No known Conditions**

Patient Signature:______________________**Date:**______________________

Patient Name:______________________

Patient #:______________________ **Date:**______________________

Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependant during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

____ ________________________

Signature of Patient or Parent/Guardian of Minor Patient Date

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, most credit cards are accepted.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered**. We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

In order to provide the best possible service and availability to all our patients, there may be a $15.00 fee for any doctor appointment not canceled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

____ ________________________

Signature of Patient or Parent/Guardian of Minor Patient Date

Patient Name:____

Patient #:________________________ **Date:**________________________

Dr. Andrew Riddle
Dr. Kelly Keener
Dr. Lauren Hitchens
Dr. Gary Morgan

Phone: (302) 422-3100
Fax: (302) 422-2900
AtlanticChiropractic.net

ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.

Gentle, Effective Care for All Ages

Record Release

I, ______________________________/___________________________,
Patient Name Date of Birth

hereby request my records and/or imaging reports be released from:

____
Organization

____
Organization

____
Organization

and to be faxed/mailed/taken to Atlantic Chiropractic Associates, P.A.

Patient/Guardian ______________________________ Date _____________

Witness ____ Date __________

Patient Name:____
Patient #:______________________________ **Date:**______________________________