# RESILIENT LIFE SOLUTIONS
# Dr. Puja Wentworth, DC
# New Patient Intake Form

**Title:** (Circle one) Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Other _____

**First Name** _____ **Middle Initial** ____ **Last Name** _____

**Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Leave Messages on:** (Circle one) Home Cell Work Don't leave messages

**Home Phone (_____)** _____-_____ **Work Phone (_____)** _____-_____

**Cell Phone (_____)** _____-_____ **Email** _____

**Date of Birth** _____/_____/_____ **Sex:** Male ☐Female

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

**Employment Status:** ☐Employed ☐Unemployed ☐FT Student ☐PT Student ☐Other_____

**Employer Data**

**Employer** _____

**Your Occupation** _____

**Spouse Data**

**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 (_____)** _____-_____

Resilient Life Solutions
Get Your Life Back

**How did you hear about our office?** _____

**Medical Conditions:** (Circle all that apply to you)

Arthritis Cancer Diabetes Heart Disease
Hypertension Psychiatric Illness Skin Disorder Stroke
¶Other _____ Fibromyalgia Asthma Osteoporosis

**Surgeries:** (Circle 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 _____

**Allergies:** (Circle all that apply to you)

Mold Seasonal Milk or Lactose Animal
Chemical _____ Sulfites Wheat/Glutens Other _____

**Social History:** (Circle 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:** (Circle 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:** (Circle one that best describes your job description)

¶Administration ¶Business Owner ¶Clerical/Secretary ¶Computer User
¶Heavy Equipment operator ¶Daycare/Childcare ¶Construction ¶Health Care
¶Food Service Industry ¶Medium Manual Labor ¶Manufacturing ¶Home Services
¶Heavy Manual Labor¶Light Manual Labor ¶Executive/Legal ¶Housekeeper
¶Other _____

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Patient Name_____Date_____

**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 | | | |

Please list all current medications being taken

_____

_____

_____

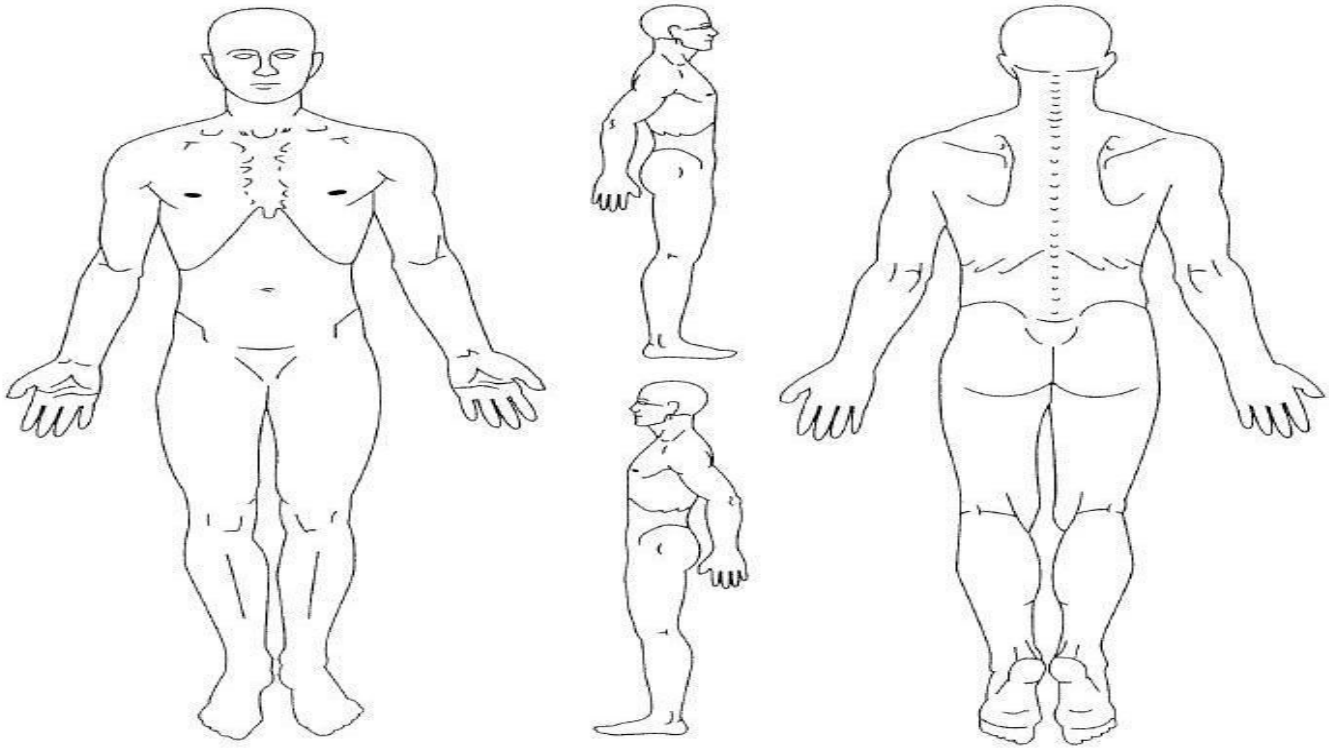
_____

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

**Are You Pregnant?** (Circle) **Yes No**

**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

**Does anything improve your pain?** Yes No **If Yes, please list:**

**When did your symptoms begin?** _____

**Are your symptoms a result of:** ☐Motor Vehicle Accident ☐Work related Accident ☐Other_____

**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 _____

Doctor's Signature _____

Office Notes:

## Resilient Life Solutions/Dr. Puja Wentworth, DC

**PAYMENT POLICY**

Thank you for choosing Dr. Puja Wentworth, DC as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We do not participate in any insurance plans, including Medicare. Payment in full is expected at the time of each visit. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage.
2. CLAIM SUBMISSION. We will give you a superbill if requested to submit if you have out of network benefits or a Health Savings Account. Your insurance company may need you to supply other information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
3. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you.
4. **Please help us to serve you better by keeping your regular scheduled appointment**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

**I have read and understood the payment policy and agree to abide by its guidelines.**

_____ _____

**Signature of patient or responsible party** **Date**