SILVER HEALTH CENTERS

Chiropractic Physical Medicine, Rehabilitation and Preventive Health Care
850 S. Greenville Ave., Ste #104 Richardson, TX 75081 972-644-6336   fax 972-644-7247

Patient Intake Form

Date___________

PATIENT INFORMATION

Last Name_____________________ First Name ______________________ S.S.N._________-________-___________

Gender: M ☐ F ☐ Age ____ Birth date ____/____/______ Marital Status: M ☐ S ☐ D ☐ W ☐

Cell Phone___________________ Email ________________________________ Home Phone____________________

Address____ City_________________ State______ Zip ___________

Employer_____________________ Occupation_____________________________ Work Phone__________________

Emergency Contact Name_____________________ Relationship______________ Phone Number__________________

How were you referred to our office?____

PRESENT SYMPTOMS

Chief complaints:____

____

Date complaints began:____

Have you lost time from work? Y ☐ N ☐ How many days lost?_______ Dates from ___________ thru_____________

What aggravates your present symptoms?____

What makes your present symptoms better? ____

Have you gone to the E.R. for this condition Y ☐ N ☐ Date____________Hospital__________________________

Have you seen another doctor for this condition? Y ☐ N ☐ Date____________ Doctor__________________________

Have you seen a chiropractor before? Y ☐ N ☐ If yes, where?____

HEALTH HISTORY

Do you have any other medical condition? Y ☐ N ☐ If yes, list below, state if receiving care and where

____

Are you currently taking any medications? Y ☐ N ☐ If yes, list medications below

____

Have you had any recent diagnostic tests (X-Rays, MRI, bloodwork)? Y ☐ N ☐ If yes, list below and when

____

Have you had any prior surgeries? Y ☐ N ☐ If yes, list all below

____

Have you had any prior motor vehicle accidents or other serious accident? Y ☐ N ☐ If yes, list and describe below

____

Did you receive care after those motor vehicle accidents?

____

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Patient Intake Form Continued

MEDICAL HISTORY

Please check below if YOU have a history of:

☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Other:____________________

Please check below if you have a FAMILY history of:

☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Other:____________________

SOCIAL HISTORY

Do you exercise? ☐ Y ☐ N If yes, how often and what____

Do you use tobacco? ☐ Y ☐ N If yes, ☐ smokeless or ☐ smoke and how often___________________________

Do you drink alcohol? ☐ Y ☐ N If yes, how many per week____

Do you drink coffee? ☐ Y ☐ N If yes, how many per day____

Do you take supplements/vitamins? ☐ Y ☐ N If yes, list____

REVIEW OF SYSTEMS

Approximate height:_______________ Approximate weight:______________

Place an X in the box of each condition you are currently experiencing or have experienced:

☐ Allergies	☐ Neck/Back Pain	☐ Numbness	☐ High Blood Pressure
☐ Weight Loss	☐ Headaches	☐ Loss of Sensation	☐ Heart Disease
☐ Obesity	☐ Arm/Leg Pain	☐ Confusion	☐ Aneurysm
☐ Loss of Appetite	☐ Bone Tumor	☐ Dizziness	☐ Angina
☐ Fatigue	☐ Fracture	☐ Slurred Speech	☐ Irregular Heart Beat
☐ Anxiety	☐ Low Bone Density	☐ Loss of Balance	☐ Heart Attack
☐ Vision Trouble	☐ Hearing Loss	☐ Kidney Infection	☐ Blood in Stool
☐ Double Vision	☐ Tinnitus	☐ Loss Bladder Control	☐ Diarrhea
☐ Night Blindness	☐ Vertigo	☐ Urine Change	☐ Abdominal Pain
☐ Glaucoma	☐ Nose Bleed	☐ Painful Urination	☐ Prostate Problem
☐ Cataracts	☐ Dry Mouth	☐ Urgency	☐ Loss Bowel Control
☐ Droopy Eyelids	☐ Change in Taste	☐ Blood in Urine	☐ Heartburn/Nausea

Are there any other health concerns you would like to discuss with the doctor? ___________________________________

____

Patient Signature______________________________ Date_______________

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Glen A. Silver, DC
Ana Cobian-Silver, DC
Juliette Tran, DC

HEALTH INSURANCE INFORMATION

Insurance Name_____________________________________Phone_________________________

Address_________________________________ City_____________ State______ Zip_________

Insured (If other than yourself)______________________________Relationship______________

Other Insured Address_________________________________Phone______________________

Member Identification #________________________ Group #_________________

ADDITIONAL INSURANCE INFORMATION

If you are covered under more than one health insurance policy, please supply the appropriate information.

Insurance Name_____________________________________Phone_________________________

Address_________________________________ City_____________ State______ Zip_________

Insured (If other than yourself) ______________________________Relationship______________

Other Insured Address_________________________________Phone______________________

Member Identification #________________________ Group #_________________

Please have your insurance card available, so we can make a copy for our records.

ASSIGNMENT OF BENEFITS

I authorize payment of the benefits relating to this claim to be paid directly to:

Silver Health Centers

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due payable.

Patient Signature______________________________ **Date**________________