

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
211 W. 10th St., Ste. B Dallas, TX 75208 214-942-1212 fax 214-942-3900

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: _____

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:

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

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

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 _____

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

HEALTH INSURANCE INFORMATION

Company Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Insured (If other than yourself) _____ Relationship _____
Other Insured Address _____ Phone _____
Adjuster _____ Claim # _____ Policy # _____

ADDITIONAL INSURANCE INFORMATION

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

Company Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Insured (If other than yourself) _____ Relationship _____
Other Insured Address _____ Phone _____
Adjuster _____ Claim # _____ Policy # _____

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

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