BOULEVARD CHIROPRACTIC
&
WELLNESS CENTER

DR. DANIEL W. SCARINGE
CHIROPRACTIC PHYSICIAN
CERTIFIED ACUPUNCTURIST

New Patient Intake Form—CONFIDENTAL

Full Name _____ Date _____

Mailing Address _____
Street City State Zip

Home Phone ( ) _____ Work Phone ( ) _____

Mobile Phone ( ) _____ E-Mail address _____

Social Security # _____ Spouse/Guardian Name _____

Marital Status. M S W D Age _____ Birth Date _____ No. of children _____

Spouse/Emergency Contact Phone _____

Occupation _____ Employer's Name and Address _____

Name of person responsible for account _____ Whom may we thank for referring you? _____

Name of Primary Care Physician _____

Address of Primary Care Physician _____

Have You Consulted With Any Other Physician For This Condition _____

INSURANCE INFORMATION

Insurance Company _____ Id # _____ Group # _____

Is patient Covered by Additional Insurance? _____

Subscriber's Name _____ Subscriber's Birth Date _____

Subscriber's Employer's Address and Phone _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage as set forth above and assign directly to Boulevard Chiropractic & Wellness Center, LLC (BCWC) and Dr. Scaringe all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize BCWC and Dr. Scaringe to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for obtaining a referral if necessary. I authorize the release of my x-rays and medical records from any provider, hospital, attorney or insurance company.

_____ _____ _____
Responsible Party Signature Relationship (self/parent/spouse) Date

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1. Primary Complaint: _____

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

Does the pain radiate anywhere? _____

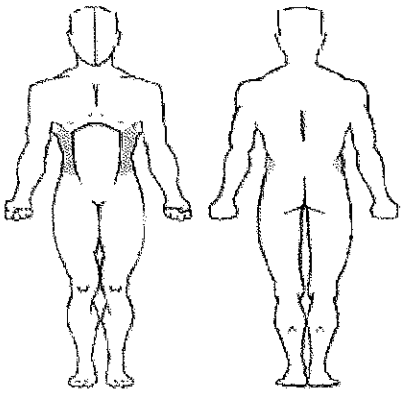
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?_____

Does it hurt more in Morning /Afternoon/ Night/All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: Phone: ( )

Location of primary complaint:



Please Mark the areas on your body where you feel the following sensations:

Pain *** Numbness ooo Pins and Needles

... Burning xxx Stabbing /// Other +++

Secondary Complain: _____

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How did it start? _____ How long ago? _____

What makes it feel better? _____

What makes it feel worse? _____

Does the pain radiate anywhere? _____

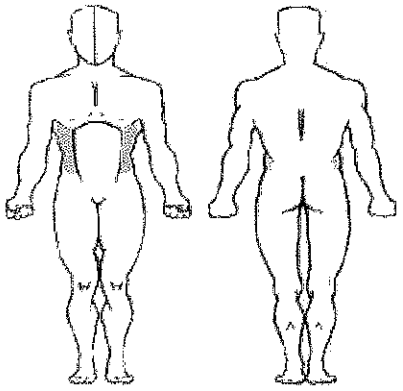
Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?_____

Does it hurt more in Morning/ Afternoon/ Night/ All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: (___) _____

Location of primary complaint:



Please Mark the areas on your body where you feel the following sensations:

Pain *** Numbness ooo Pins and Needles

... Burning xxx Stabbing /// Other +++

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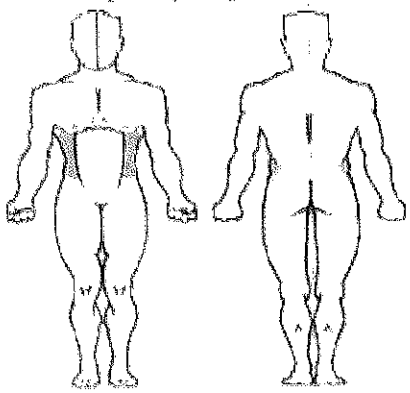
Third Complaint:_____

Location of primary complaint:



Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Worst	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At its Best	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How did it start? _____ How long ago? _____

What makes it feel better?

What makes it feel worse? _____

Does the pain radiate anywhere? _____

Have you had a MRI, X-ray, CTscan on this area? Yes/No Where?_____

Does it hurt more in Morning/ Afternoon/ Night/ All Day (please circle)

Have you seen anyone for this condition? Yes/No

If yes who? Name: _____ Phone: (___) _____

Please Mark the areas on your body where you feel the following sensations:

Pain ^^^ Numbness ooo Pins and Needles

... Burning **XXX** Stabbing *III* Other +++

II. Past Medical History

Please list any surgies you have had and the date:_____

List of Medications you are currently on: _____

List of Vitamins/Herbs you currently take: _____

Do you have any allergies (food, medications, environmental)?

_____

Are you currently pregnant? _____

Do you have any of the following habits: smoking_____ # packs per day alcohol_____drinks per week

coffee_____cups/day stress level_____ reason

Any additional concerns please list here: _____

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III. HEALTH HISTORY:

Mark the following conditions you may have had or have now ("-" have had, "+" have now)

___Allergy	___Diarrhea	___Measles	___Rheumatic Fever	___Alcoholism	___Eczema
___Miscarriage	___Stroke	___Anemia	___Multiple Sclerosis	___HIV (AIDS)	___Gout
___Arteriosclerosis	___Emphysema	___Mumps	___Sinus Problems	___Arthritis	___Neuritis
___High Blood Pressure	___Asthma	___Nervousness	___Thyroid Problems	___Ulcers	___Cancer
___Heart Disease	___Depression	___Convulsions	___Venereal Disease	___Malaria	___Pleurisy
___Constipation	___Pneumonia	___Cold Sores	___Whooping Cough	___Polio	___Neck Pain
___Gall Bladder Problems	___Migraines	___Headaches	___Menstrual Cramps	___Back Pain	___Epilepsy
___Irregular Periods	___ Heart Attack	___Tuberculosis	___Low Blood Sugar	___ Diabetes	___Ringing in Ears

___Other: (Please Explain) _____

IV. Social History – Example: Smoking, Drinking, Exercising ..... How Long or how much?

_____

_____

_____

Have you been in an auto accident? Yes/No ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe _____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years

Do you currently have an open workman's compensation or personal injury case? Yes / No

If you have an open case, please tell us your attorney's name : _____

V. Services: Please indicate all services that you wish to receive or in which you may be interested:

Chiropractic:
- ☐ Adjustments
- ☐ Physical Therapy
- ☐ Exercises

Acupuncture:
- ☐ Emotional Issues
- ☐ Addictions
- ☐ Fatigue
- ☐ Chronic Pain
- ☐ Insomnia/Sleeping Disorders
- ☐ Stop Smoking
- ☐ Appetite Control

Orthotics:
- ☐ Foot Scans/Analysis

Other: _____

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VI. STRESSES

The following tree areas of stress can cause a misaligned vertebra and nerve system interference. Please circle when you experienced these stresses: C (Child), T (Teenager), A (Adult), or N (Not at all).

PHYSICAL STRESS:					Explain
Birth Traumas (as a mother or child)	C	T	A	N	
Slips/Falls	C	T	A	N	
Car Accidents	C	T	A	N	
Sports Injuries	C	T	A	N	
Physical abuse	C	T	A	N	
Work Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Sitting on your wallet for years	C	T	A	N	
Sleeping Position – Stomach	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Driving for Many Hours	C	T	A	N	
Continuous Hour Sitting/Standing	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	

EMOTIONAL/MENTAL:					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Money	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Hold in Feelings	C	T	A	N	
Quick Tempered	C	T	A	N	
Verbal Abuse	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of Loved One	C	T	A	N	

CHEMICAL:					Explain
Environment (i.e. pollution)	C	T	A	N	
Smoker-Amount?	C	T	A	N	
Second-hand smoke	C	T	A	N	
Poor diet	C	T	A	N	
Caffeine Amount?	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-the-counter Drugs	C	T	A	N	

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VII. Family History: Some health conditions are the result of hereditary weakness. Information about immediate family members, brothers, sisters, parents, grandparents will give us a better understanding of your total health picture.

Relationship	Present and Past Health Problems

END