CROSSROADS HOLISTIC HEALTH CENTER - NEW PATIENT INTAKE FORM

Name:_____ Cell #_____

Home#_____Work#_____Email:_____

Address:_____

SSN:_____ Sex: M/F Status: M/S/W/D No. of children:_____DOB:_____

Driver Lic #_____Occupation:_____Referred by:_____

Employer:_____ Contact #_____

Employer's address:_____

Length of time employed:_____Person responsible for this account:_____

Spouse name:_____Contact #_____

Address:_____

_____

What is your major health issue?_____

Other complaints:_____

How long have your had this condition?_____What activities aggravate this condition?_____

_____How long is it since you felt really good?_____

Are you taking any medications? Y/N What kind?_____

Any non-prescription drugs? Y/N What kind?_____

Other Doctors seen for this condition: MD/DC/DO/DDS Doctor's Name_____

X-rays/MRI/CT scan: Y/N Blood tests: Y/N Other trests:_____Diagnosis:_____

_____

Physiotherapy: Y/N Results_____Were you off work? Y/N

If so, how long?_____Would you like us provide statements for you to bill your insurance company? Y/N

_____

Were you involved in an accident – **automobile** or **injured at work** or **other:**_____

Location:_____Date:_____Time:_____

Description of accident:_____

_____Were you unconscious: Y/N Fractures: Y/N Cuts: Y/N

Abrasions: Y/N Bruises: Y/N Hospital stay: Y/N How long?_____Doctor:_____

Hospital:_____Injury reported to employer? Y/N Supervisor:_____

Contact #_____.Have you had any other personal injury cases or accidents? Y/N Describe:_____

_____

Do you have an attorney? Y/N Name and address_____

_____

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

Patient Signature……Date……