

# Atlantic Spine Clinic Intake Form

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## PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, allowing our front office to potentially pre-verify your insurance and allowing our providers to pre-screen your case. This will speed up your initial office visit and allow us to more efficiently serve your healthcare needs.

## ABOUT YOU

### Personal Identification Information

First Name \_\_\_\_\_

Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

DOB \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Do we have your permission to contact your doctor regarding your care in our office?  
 Yes  No

Who is your cell phone provider? (For Text Message Appointment Reminders)  
 ATT  Verizon  T-Mobile  Boost  Mint Mobile  US Cellular  Other

### Home Address

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Contact Information

Mobile Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Primary Email Address \_\_\_\_\_

I consent to receive transactional messages from Atlantic Spine Clinic at the phone number provided. Message frequency may vary. Message and data rates may apply. Reply STOP to opt out.

Yes  No

I consent to receive marketing and promotional messages from Atlantic Spine Clinic at the phone number provided. Message frequency may vary. Message and data rates may apply. Reply STOP to opt out.

Yes

### Demographic Information

Sex:  
 Male  Female

Marital Status:  
 Single  Married  Divorced  Widowed  Minor  Other

Spouse's Name \_\_\_\_\_

Ages of any children \_\_\_\_\_

Race/Ethnicity

White/Caucasian  Black  Hispanic/Latino  Asian  Native American  Pacific Islander  Other  Decline to Answer

Do you plan to use your health insurance?

Yes  No

PRIMARY INSURANCE INFORMATION

Primary Insurance Company

Member ID/Policy #

Group Number

Patient Relationship to Primary Insured

Self  Spouse  Minor  Caregiver  Other

If possible, upload the FRONT AND BACK of your Primary Insurance Card

Assignment and Release I certify that I (or my dependent) have insurance coverage with the carrier whose information has been provided to the front office and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Atlantic Spine and Health Clinic, the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the physicians to release all information necessary, including the diagnosis, and the records of any examinations or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature

Date

Emergency Contact Information

Emergency Contact Name:

Contact Phone Number:

Relationship to Patient:

Employer Information

Employment Status:

Employed  Student  Not Employed  Retired  Unknown

Employer Name:

Occupation:

Referral Information

How did you hear about us?

Existing Patient  Referral from Doctor  Walk-In  Google  Google Maps  Yelp  Facebook/Instagram  Nextdoor  Insurance Company  Other

Referring Physician:

Referring Patient:

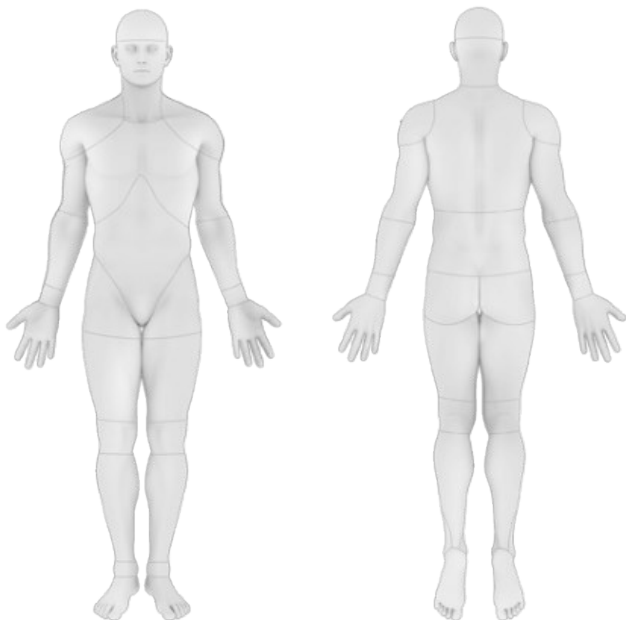
VISIT PURPOSE

Select the main reason for this visit: If your injury is AUTO or WORK Related PLEASE STOP HERE and contact our office.

- Exercise Injury
- Lifting Injury
- Acute Injury
- Chronic Condition Acutely Exacerbated
- Auto Accident (Personal)
- Wellness/Maintenance
- Other

PRIMARY COMPLAINT

What is your primary area of concern? Select only one area. We will ask about additional complaints after we gather information about this first area of concern. You may include additional details about the specific region, below.



If necessary, explain details of your pain here.

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Approximate date this condition began? (Does not need to be an exact date. Ex. 1-2 days/weeks/months ago)

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What caused this condition?

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What term(s) describes your discomfort or pain as it relates to that region? Choose all that apply.

- |                                    |   |                                     |
|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Tightness | <input type="checkbox"/> Stiffness      | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Burning        | <input type="checkbox"/> Throbbing  |
| <input type="checkbox"/> Dullness  | <input type="checkbox"/> Sharp/Shooting | <input type="checkbox"/> Stabbing   |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Numbness       | <input type="checkbox"/> Weakness   |

Rate the severity of your discomfort at its worst, on a scale of 0 - 10 where 0 is no pain and 10 is severe pain

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How often do you feel this discomfort?

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How has this complaint changed since onset?

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What improves this condition or gives you relief? Select YES or NO for all questions.

	Yes	No
Nothing		
Over-the-Counter Medications		
Prescription Medications		
Chiropractic Care		
Cold/Ice		
Heat		
Exercise		
Rest		
Stretching		
Massage		
Work		
Physical Therapy		
Acupuncture		

If other, specify:

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What aggravates this condition? Select YES or NO for all questions.

	Yes	No
Any movement		
Activity and/or exercise		
Running or biking		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Driving		
Household chores (cleaning, cooking, etc.)		
Pulling or pushing		
Self-care (dressing, bathing, etc.)		
Sitting		
Squatting		
Standing		
Walking		
Yardwork		

If other, specify:

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What treatment, if any, have you received since the injury? Select YES or NO for all questions.

	Yes	No
No treatment yet received		
Chiropractic Treatment		
Physical Therapy		
Massage		
Over-the-Counter Medications		
Prescribed Medications		
Medical Injection Treatment		
Surgical Treatment		
Natural or Holistic Treatment		
Acupuncture		
Dry Needling		
Other		

If other, specify:

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Have other health care provider(s) performed tests or imaging related to this condition?

Yes

No

What imaging or tests?

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Have you ever had any previous episodes of this condition?

Yes

No

If yes, explain details here.

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Do you have a secondary condition or another concern?

Yes

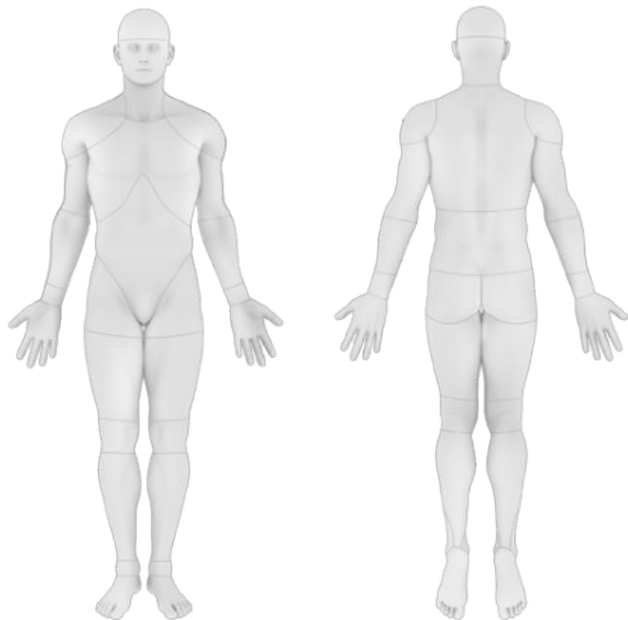
No

If yes, explain details here.

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SECONDARY AREA OF CONCERN

What is your secondary area of concern?



Specific details can be included here.

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Approximate date this condition began? (# days/weeks/months)

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What caused this condition? (Unknown if unsure)

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What term(s) describes your discomfort or pain as it relates to that region? Choose all that apply.

- |                                    |   |                                     |
|------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Tightness | <input type="checkbox"/> Stiffness      | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Burning        | <input type="checkbox"/> Throbbing  |
| <input type="checkbox"/> Dullness  | <input type="checkbox"/> Sharp/Shooting | <input type="checkbox"/> Stabbing   |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Numbness       | <input type="checkbox"/> Weakness   |

Rate the severity of your discomfort at its worst, on a scale of 0 - 10 where 0 is no pain and 10 is severe pain

---

How often do you feel this discomfort?

---

How has this complaint changed since onset?

---

What improves this condition or gives you relief? Select YES or NO for all questions.

	Yes	No
Nothing		
Over-the-Counter Medications		
Prescription Medications		
Chiropractic Care		
Cold/Ice		
Heat		
Exercise		
Rest		
Stretching		
Massage		
Work		
Physical Therapy		
Acupuncture		

If other, specify:

---

What aggravates this condition? Select YES or NO for all questions.

	Yes	No
Any movement		
Activity and/or exercise		
Running or biking		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Driving		
Household chores (cleaning, cooking, etc.)		
Pulling or pushing		
Self-care (dressing, bathing, etc.)		
Sitting		
Squatting		
Standing		
Walking		
Yardwork		

If other, specify:

---

What treatment, if any, have you received since the injury? Select YES or NO for all questions.

	Yes	No
No treatment received		
Chiropractic Treatment		
Physical Therapy		
Massage		
Over-the-Counter Medications		
Prescribed Medications		
Medical Injection Treatment		
Surgical Treatment		
Natural or Holistic Treatment		
Acupuncture		
Dry Needling		
Other		

If other, specify:

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Have other health care provider(s) performed imaging or tests related to this condition?

Yes  No

What imaging or tests were performed?

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Do you have an additional area of concern?

Yes  No

Please describe your additional concerns in as much detail as necessary.

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#### PATIENT HEALTH HISTORY

Are you currently taking any medications?

Yes  No

Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily). IF MORE THAN 3 MEDICATIONS, BRING A COPY OF MEDICATION LIST TO YOUR FIRST APPOINTMENT.

	Medication Name	Dosage/Frequency
1		
2		
3		

Other than the condition(s) already shared, do you have any additional health concerns related to any of the body systems below? Select YES or NO for all questions.

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

If you have answered yes to any of the above, please share details below.

Do you have any Medication Allergies? If NO, leave blank.

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

#### PERSONAL AND FAMILY HISTORY

Select YES or NO for all questions.

	Yes	No
Have you had any surgeries or hospitalizations?		
Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		
Do you have a past family illness history, such as heart disease, diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?		

If you answered YES to any of the answers above, please share details here.

#### WORK/SOCIAL HABITS

Current Work/Activity Habits - Choose all that apply.

- Full-time (30-40+ hours/week)
  Part-time (1-30 hours/week)
  Retired
  Student
  Homemaker
  Permanently Fully Disabled
  Permanently Partially Disabled
  Cannot work due to current condition
  Unemployed

Social Habits. Select YES or NO for all questions.

	Yes	No
Smoke or Use Tobacco Products		
Drink Alcohol		
Drink Caffeine		
Use Recreational Drugs		

If YES to any answers above, detail frequency here.

**Exercise Habits. Select YES or NO for all questions.**

	Yes	No
No Current Exercise		
Exercise Daily		
Exercise 3+ Times per Week		
Cannot Return to Exercise due to Current Condition		

**Sleep Positional Habits.**

- On Back
  Side-Lying
  Stomach  
 Side 50% / Back 50%

**Diet and Nutrition Habits. Select YES or NO for all questions.**

	Yes	No
Vegan or Vegetarian		
Daily Supplements		

Additional Dietary/Nutritional details can be included here

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**NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE Do you or have you ever experienced any of the following situations or symptoms? Select YES or NO for all questions.**

	YES	NO
Weakness, numbness, or burning in your shoulder, arms, or hands?		
Do your arms or hands fall asleep regularly?		
Reduced sensation or swelling in your arms or hands?		
Loss of grip strength?		
Weakness, numbness or burning in your buttocks, legs, or feet?		
Do your legs or feet fall asleep regularly?		
Reduced sensation or swelling in your legs or feet?		
Cold hands or feet?		
Bladder/Urinary Dysfunction?		
Have you ever had an MRI?		

If yes to MRI, What location was it ordered for and when was the MRI?

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I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my examination.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date