

**ZEN HEALTH CENTER****Chiropractic Intake Form****Date:** \_\_\_\_\_**POLICY AND PATIENT DATA**

1. PAYMENT is due at the time of service, unless other arrangements have been made.
2. AN INSURANCE CONTRACT is between the patient and the patient's insurance company; therefore it is the responsibility of the patient to keep the account current.
3. Patients involved in LITIGATION (lawsuits) are, as are others, responsible for their service here at the clinic.
4. We reserve the right to BILL FOR MISSED APPOINTMENTS.
5. Personal cleanliness is requested due to the close interpersonal nature of this work.

**Title:**  Mr.  Mrs.  Ms  Miss (check one)

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Address Line 1:** \_\_\_\_\_

**Address Line 2:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  Male  Female **Email:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:**  Single  Married  Other

**Employment Status:**  Employed  Full Time Student  Part Time Student  Other (check one)
**Spouse Data**
**If you are insured under your spouse, please provide their Social Security Number below.**
**Is your spouse a patient in the clinic?**  Yes  No

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
**Employer Data**
**Your Occupation:** \_\_\_\_\_

**Employer's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Insurance Information**

---

Type:  Auto Accident  Work Injury  Health Insurance  Medicare  Other (check one)

**SKIP THE REMAINDER OF THIS SECTION IF WE MADE A PHOTOCOPY OF YOUR INSURANCE CARD(S) UNLESS YOU ARE INSURED BY SOMEONE OTHER THAN YOURSELF**

Primary Insurance: \_\_\_\_\_ Insurance Phone# \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Phone# \_\_\_\_\_  Male  Female

Relationship to Insured:  Self  Spouse  Child Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy/Group# \_\_\_\_\_ Insured's ID# \_\_\_\_\_

**Emergency Contact**

---

Contact Name: \_\_\_\_\_

Contact Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Additional Information**

---

Is it okay to call you at work?

Yes  No

How did you hear about our clinic? Or who referred you?

Family member  Physician  Google Search  Yellow Pages (HawaiianTel)  
 Friend  Attorney  Yahoo/Bing/Other Online  Other

If you selected 'family member', 'friend', or 'physician' please enter their name below:

\_\_\_\_\_

If you selected 'other' please describe:

\_\_\_\_\_

**Medical Conditions:**

Arthritis  Cancer  Diabetes  Heart Disease  
 Hypertension  Psychiatric Illness  Skin Disorder  Stroke

**Surgeries:**

Appendectomy  Cardiovascular procedure  Cervical disc procedure  Hysterectomy  
 Joint replacement  Laminectomies  Radical prostatectomy  Transurethral prostate surgery

**Allergies:**

Eggs  Fish and Shellfish  Milk or Lactose  Peanut  
 Soy  Sulfites  Wheat/Gluten

**Social History:**

Caffeine used occasionally  Caffeine used often  Chew tobacco occasionally  Chew tobacco often  
 Drink alcohol occasionally  Drink alcohol often  Exercise not at all  Exercise occasionally  
 Exercise often  Experience stress occasionally  Experience stress often  Smoke 1 pack or less per day  
 Smoke 1 pack or more daily  Wear seat belts always  Wear seat belts never  Wear seatbelts usually

**Family History:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent)      | <input type="checkbox"/> Arthritis (sibling)      | <input type="checkbox"/> Cancer (parent)              | <input type="checkbox"/> Cancer (sibling)              |
| <input type="checkbox"/> Cholesterol (parent)    | <input type="checkbox"/> Cholesterol (sibling)    | <input type="checkbox"/> Diabetes (parent)            | <input type="checkbox"/> Diabetes (sibling)            |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent)    | <input type="checkbox"/> Psychiatric (sibling)    | <input type="checkbox"/> Stroke (parent)              | <input type="checkbox"/> Stroke (sibling)              |
| <input type="checkbox"/> Thyroid (parent)        | <input type="checkbox"/> Thyroid (sibling)        |   |  |

**Substance Use:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past)      | <input type="checkbox"/> Alcohol (present)      | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past)      | <input type="checkbox"/> Cocaine (present)      |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past)       | <input type="checkbox"/> Heroin (Present)       |
| <input type="checkbox"/> Marijuana (past)    | <input type="checkbox"/> Marijuana (present)    |  |   |

**Male Children:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

**Female Children:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

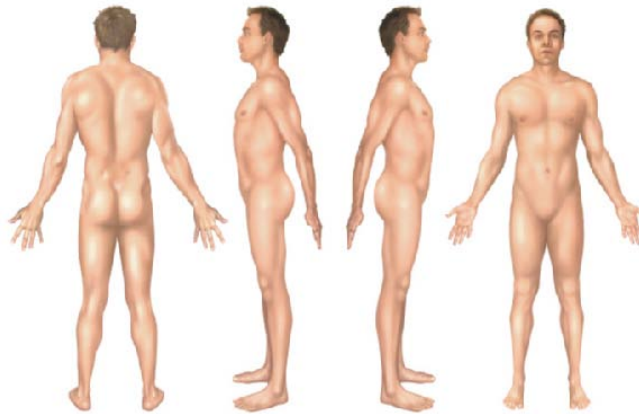
**Occupational Activities:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner           | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user         |
| <input type="checkbox"/> Construction   | <input type="checkbox"/> Daycare/childcare        | <input type="checkbox"/> Executive/legal      | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care    | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor   | <input type="checkbox"/> Home services         |
| <input type="checkbox"/> Household      | <input type="checkbox"/> Light manual labor       | <input type="checkbox"/> Manufacturing        | <input type="checkbox"/> Medium manual labor   |

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

- # = Numbness      X = Burning      / = Stabbing      0 = Pins & Needles      + = Dull Ache

Electronic Version: Describe Below



Describe your symptoms: \_\_\_\_\_

When did your symptoms start?    Month \_\_\_\_\_    Day \_\_\_\_\_    Year \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

**How often do you experience your symptoms?**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Constantly<br>(76-100% of the day) | <input type="checkbox"/> Frequently<br>(51-75% of the day) | <input type="checkbox"/> Occasionally<br>(26-50% of the day) | <input type="checkbox"/> Intermittently<br>(0-25% of the day) |
|---|--|--|---|

**What describes the nature of your symptoms?**

- |                                  |                                    |                                   |                                   |
|----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp   | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb     | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling  | <input type="checkbox"/> Stabbing |                                   |

**How are your symptoms changing?**

- Getting better                       Not changing                       Getting worse

**During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)**

- 0 None                       1                       2                       3  
 4                       5                       6                       7  
 8                       9                       10 Unbearable

**During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):**

- Not at all                       A little bit                       Moderately                       Quite a bit  
 Extremely

**During the past 4 weeks, how much of the time has your condition interfered with your social activities?**

- All of the time                       Most of the time                       Some of the time                       A little of the time  
 None of the time

**In general, would you say your overall health right now is....**

- Excellent                       Very good                       Good                       Fair  
 Poor

**Who have you seen for your symptoms:**

- No one                       Other Chiropractor                       Medical Doctor                       Physical Therapist  
 Other

**What treatment did you receive for your symptoms?**

- Adjustments                       Physical Therapy                       Medication                       Surgery  
 Other

**When did you receive this treatment?**

- In the last month                       2 – 3 months ago                       3 – 6 months ago                       6 months to 1 year ago  
 1 – 2 years ago                       2 – 5 years ago                       5 – 10 years ago

**What tests have you had for your symptoms?**

- X-rays                       MRI                       CT Scan                       Other

**When were these tests done?**

- In the last month                       2 – 3 months ago                       3 – 6 months ago                       6 months to 1 year ago  
 1 - 2 years ago                       2 – 5 years ago                       5 – 10 years ago

**Have you had similar symptoms in the past?**

- Yes                       No

**If you have seen treatment in the past for the same or similar symptoms, who did you see?**

- This Office                       Other Chiropractor                       Medical Doctor                       Physical Therapist  
 Other

**What is your occupation?**

- Professional/Executive                       White Collar/Secretarial                       Tradesperson                       Laborer  
 Homemaker                       Full-time Student                       Retired                       Other

**If you are not retired, a homemaker or a student, what is your work status?**

- Full-time                       Part-time                       Self-employed                       Unemployed  
 Off work                       Other

My signature is an acknowledgement that I have read the policy above and agree to abide by the same and authorize the office of Hong Zeng Yuen-Schat (Dr. Zen), D.C. to treat and/or release any medical information necessary to process this claim and request payment of benefits to either to myself or to the party who accepts assignment below.

---

Signature of Patient

---

Date

Electronic Version: Type Full Name