



PIETREK SPINAL CARE

NEW PATIENT INTAKE FORM

Dr. James Pietrek
NUCCA Chiropractor

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Date _____ / _____ / _____

Name _____

Address _____

Apt.# _____

City _____

State _____ Zip Code _____

E-Mail _____

Referred By _____

Cell Phone _____

Home Phone _____

Work Phone _____

Age _____ Birth Date _____ / _____ / _____

Marital (circle one): Married Single Widowed Divorced How many Children? _____

Occupation (if dependent list parent's occupation) _____

Employer _____

Address _____

City _____

State _____ Zip Code _____

Name of Spouse _____

Occupation _____

Employer _____

Office Phone _____

Emergency Contact _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Cash Check Visa/MC

Person responsible for payment

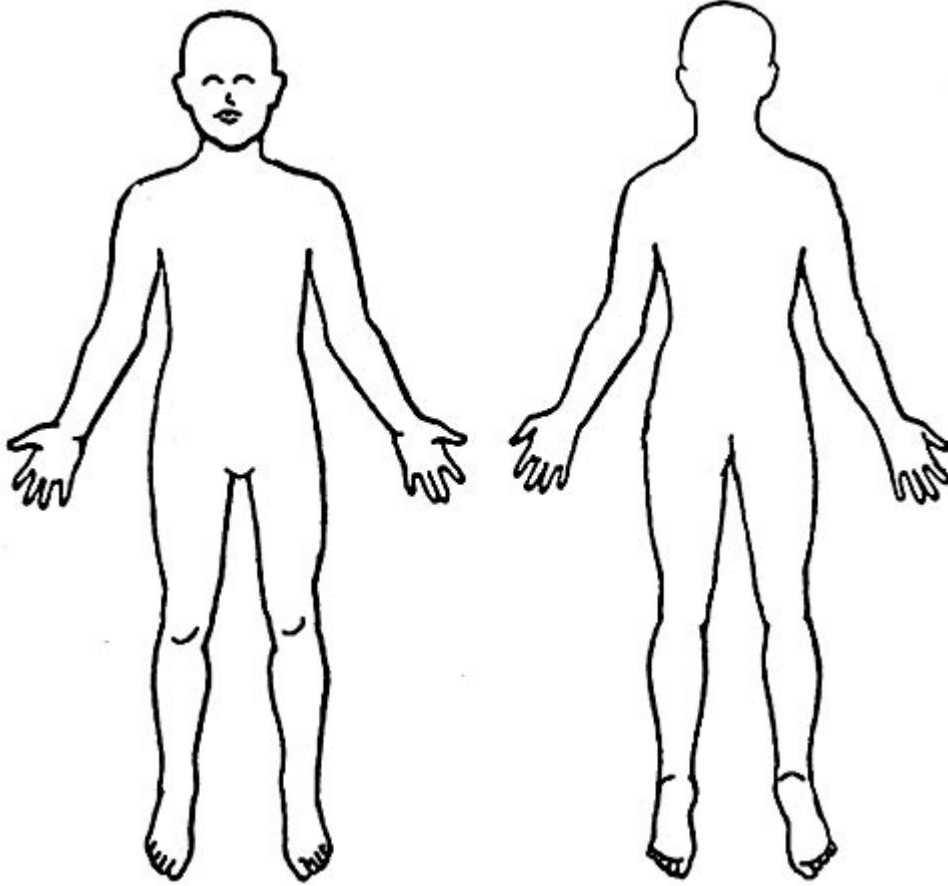
Name _____ Phone _____

Purpose for this appointment _____

Other Doctors seen for this Condition _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe _____



CONFIDENTIAL HEALTH HISTORY

Please outline on the diagram the area of your discomfort.

Please describe your present complaints

Please check any of the following that apply to your current/past medical history:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Belching or gas | <input type="checkbox"/> Gout | <input type="checkbox"/> Weakness in arms |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Slow heart beat |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Itching | <input type="checkbox"/> Bad posture |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Burning sensations |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema/Hives |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Polio | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sprained ankle | <input type="checkbox"/> Weakness in legs | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> Vomiting of blood | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Low backache | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Painful tailbone | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Dentures | <input type="checkbox"/> Numbness in arms/hands |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Stiff or painful neck | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Poor urine control | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Low blood pressure | |
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Poor appetite | |

For Women Only:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Premenstrual tension | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Excessive flow | <input type="checkbox"/> Unable to get pregnant | | |

Is there a possibility that you may be pregnant? YES NO

Date of last menstrual period _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time services are rendered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

PRIVACY NOTICE:

This office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to the use of your name.

By way of signing this form, I release this office from all liability and authorize the use of my last name for the purpose of greeting me, announcing me into a room, or around the office in the presence of others.

Patient's Name (print) _____

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

APPOINTMENT POLICY

This office reserves the right to charge a \$25 fee for missed appointments and those appointments canceled without exactly 24 hours notice.

By way of signing this form, I state that I understand the financial policy of this office.

Patient's Signature _____ Date _____