EPIC Chiropractic P.C.
10290 Chapel Hill Road Ste 500
Morrisville, NC 27560

919.634.3263
epicchiropracticpc.com
epicchiro@outlook.com

New Patient Intake Form

_____
Name

_____
Phone Number E-Mail

_____
Address

_____
City State Zip

_____
Date of Birth Gender

Height: ___feet ____inches Weight:_____lbs.

_____
Emergency Contact Relationship Phone Number

How did you hear about us?
___Word of mouth (from:_____)
___Advertisement ___Web Search
___Social Media ___Event
___Other: _____

_____
Employment Status Occupation Employer Name

_____
Work Duties

_____
Date of last chiropractic visit Name of chiropractor & office visited

_____
Reason for previous chiropractic care

_____
Date of last physical exam Name of primary care provider

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Purpose of today's visit:

__Wellness
__Complaint
__Recent Injury
__Other:_____

_____
Location(s) of chief complaint

_____
Describe how & when the injury, pain, or discomfort originated

Describe your pain/discomfort:

_____

_____

Frequency of pain/discomfort:
___Always ___Daily ___Mornings ___Evenings ___Occasionally

Does your condition interfere with any of your daily activities or routines: ___Yes ___No

If 'yes', list the activities it affects: _____

_____

What makes your pain/discomfort feel better:_____

_____

What makes your pain/discomfort feel worse:_____

_____

What is the quality of your pain/discomfort: (*circle all that apply*)

Dull	Achy	Sharp	Tingling	Numb	Stabbing
Deep	Annoying	Burning	Heavy	Pulling	Shock-like
Shooting	Stiffness	Tightness	Throbbing	Diffuse	

Does your discomfort radiate: ___Yes ___No
If 'yes', please describe where:_____

Please list any other associated signs or symptoms:

_____

_____

Please rate your discomfort on a scale of 1-10 (10 being the max. pain) (circle your answer):
1 2 3 4 5 6 7 8 9 10

Has this condition affected your sleep: ___Yes ___No

Has this condition affected your appetite or thirst: ___Yes ___No

Does the weather affect your pain/discomfort: ___Yes ___No

Have you received any other care for this condition: ___Yes ___No
If 'yes', please describe where and what treatment(s) were performed:_____

_____

_____
Date of last images Type of images taken (i.e. X-rays, MRI, CT Scan, etc.)

Are you pregnant, trying to get pregnant, or have any plans to get pregnant in the next year
___Yes ___No

Please list any additional health conditions you have been treated for in the last 2 years:

Please list all current medications:

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Previous Health History *(Please provide a date of incident & brief explanation for each 'Yes')*

Broken bones: ___Yes ___No

Major sprains/strains: ___Yes ___No

_____

Hospitalizations: ___Yes ___No

Surgeries: ___Yes ___No

_____

Been struck unconscious: ___Yes ___No

Auto accident: ___Yes ___No

_____

Other traumatic event: ___Yes ___No

Stroke: ___Yes ___No

_____

Eating disorder: ___Yes ___No

_____

Please circle all current or previous health related conditions. For those circled, please briefly describe on the lines below this section (*continued on next page*):

Allergies	Alcoholism	Anemia
Arteriosclerosis	Arthritis	Asthma
Autoimmune Disease	Back Pain	Bleeding Disorders
Bone Disease	Breast Lump	Bronchitis
Bruise Easily	Cancer	Cardiovascular Disease
Cataracts	Chest Pain	Concussion
Congestive Heart Failure	Cold Extremities	Constipation
COPD/Emphysema	Cramps	CVA (Stroke/TIA)
Dementia/Alzheimers	Depression	Diabetes
Digestion Problems	Diagnosed Emotional/Mental Disorder	
Dizziness/Vertigo	Epilepsy	Eye Pain/Blurriness

Fatigue	Frequent Urination	Gallbladder Disease/Stones
Glaucoma	Gout	Headache
Hemorrhoids	Hernia	Herniated Disc
High Blood Pressure	Hot Flashes	IBS
Irregular Heartbeat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Liver Disease/Cirrhosis	Loss of Memory
Loss of Balance	Loss of Smell	Loss of Taste
Lung Disease	Macular Degeneration	Migraines
Nosebleeds	Pacemaker	Parkinson’s
Polio	Poor Posture	Prostate Trouble
Reflux	Retinal Disease	Sciatica
Seizures	Shortness of Breath	Sinus Infection
Sleep Problems/Insomnia	Skin Sensitivity	Smoked
Spinal Curvatures	Swelling in Ankles	Swollen Joints
Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Other

_____

_____

_____

_____

Social & Life Choices

(If 'Yes', please check the frequency below each category listed)

Alcohol: ___Yes ___No
___Daily ___Weekly ___Monthly

Drug use: ___Yes ___No
___Daily ___Weekly ___Monthly

Energy drinks or soda: ___Yes ___No
___Daily ___Weekly ___Monthly

Smoking: ___Yes ___No
___Daily ___Weekly ___Monthly

Approx. daily water intake: _____ounces

Please describe your diet below (i.e. balanced, restricted, vegan, etc):

_____

Please list all current Vitamins/Supplements:

Exercise: ___Yes ___No
If 'Yes', please describe your exercise routine:_____

_____

Stretching: ___Yes ___No
If 'Yes', please check how frequent: ___Daily ___Weekly ___Monthly

Family Health History

Please list diagnosed health conditions of any parents, siblings, or grandparents (i.e. arthritis, cancer, diabetes, heart disease, kidney disease, high blood pressure, etc.):

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Patient Messaging Consent:

By signing below and supplying my phone number, e-mail, and any other contact information above, I authorize EPIC Chiropractic and their staff to contact me in regards to upcoming appointments, missed appointments, balances due, medical information, or any other necessary communication via a messaging system through their EHR system.

_____

Patient Signature *Date*

Payment Data Saved on File Consent:

By checking "Yes", signing below, and supplying necessary payment information, I authorize EPIC Chiropractic and their staff to save my necessary payment information for automated payments for balances due. All payment information will be saved to EPIC Chiropractic EHR system in encrypted form in a secure payment gateway with no information displayed on screen and by PCI DSS credit card compliance regulations. All payments made can have a receipt printed or e-mailed to you upon request.

___*Yes* ___*No*

_____

Patient Signature *Date*

Media Use Consent:

By checking "Yes" and signing below, I authorize EPIC Chiropractic and their staff to take and utilize photographs, videos, and testimonials of me for the purpose of marketing, education, and/or entertainment on social media platforms, office website, and other forms of media/ads.

___*Yes* ___*No*

I give consent, but would like my name to remain anonymous: ____

I give consent and in formats where my name will be shared, I would like it to appear as written below:

_____

Printed Name

_____

Patient Signature *Date*