SoftWave Therapy

Hawk Nation Health Center

CONTOUR LIGHT

Patient Intake Form

Patient Name: ____________________________________ Date : ________________

Name you prefer to be called: _________________________ Social Security #: _______________

Date of Birth (mm/dd/yyyy) : _________________________ Gender: ❍ Male ❍ Female

Marital Status: ❍ Single ❍ Married ❍ Other Significant Other's Name: ___________________

Work Status:
❍ Employed
❍ Full-Time Student
❍ Part-Time Student
❍ Retired
❍ Other

How did you hear about us?
❍ Internet Search
❍ Facebook
❍ Television
❍ Event _______________
❍ Other _______________

Email: ____

Street Address: ____

City: ___________________________ State: ________ Zip: __________

Cell Phone: _____________________ Work Phone: ______________________

Number of Children: ______ # at Home: _____

Child Name: __________________ Age: _____

Child Name: __________________ Age: _____

Child Name: __________________ Age: _____

Child Name: __________________ Age: _____

Primary reason for your visit?

Which medical practitioners or specialists are you currently seeing?

____

Have you ever been to a chiropractor before? ❍ Yes ❍ No

If yes, approximate date of last visit _____/_____/______ How long did you receive care? ____________

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Health History

Patient Name: ____ Date : ___________________

Height : _____________ Current Weight : _____________ Your Goal Weight: _____________

Do you consider your health an (check one): ❍ Investment ❍ Expense

Pain Indicators (check all that currently apply)

❍ Headaches	❍ Elbow pain	❍ Upper Back pain	❍ Hip pain
❍ Neck pain	❍ Wrist pain	❍ Mid Back pain	❍ Knee pain
❍ Shoulder pain	❍ Hand pain	❍ Low Back pain	❍ Ankle/Foot pain

Medical History (check all that currently apply)

❍ High Cholesterol	❍ Allergies	❍ Arthritis	❍ Significant Trauma
❍ High Blood Pressure	❍ Sinuses	❍ Surgeries	❍ Sleep Problems
❍ Diabetes	❍ Asthma	❍ Acid Reflux	❍ Weight Problems
❍ Thyroid Disease	❍ Vertigo	❍ Digestive Problems	❍ Infertility
❍ Heart Disease	❍ Ulcer(s)	❍ Chronic Loose Stools	❍ Stress / Irritability
❍ Kidney Disease	❍ Fatigue	❍ Fibromyalgia	❍ Skin Condition(s)

Are you currently pregnant or breast feeding? ❍ Yes ❍ No

Do you currently have active cancer or cholecystitis? ❍ Yes ❍ No

Most recent car accident (date)? : ____________

List medications/prescriptions (with dosage and frequency): ______________________________

____

Lifestyle (check all that currently apply)

❍ Stress/Anxiety	❍ Poor Snacks	❍ Caffeine	❍ Always Hungry
❍ Chronic Pain	❍ Skipping Meals	❍ Alcohol	❍ Poor Sleep/Tired
❍ Little/No Exercise	❍ High Sugar Intake	❍ Under/Over Eat	❍ Nervous

List vitamins/minerals/supplement currently taking: _____________________________________

____

Do you exercise? ❍ Never ❍ 1-2 Times a Week ❍ 3+ Times a Week

What type of exercise do you do? ❍ Run ❍ Weights ❍ Yoga ❍ Walk ❍ Other _______________

Job Requirements: ❍ Sit ❍ Stand ❍ Bend ❍ Lift ❍ Carry ❍ Travel

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Signature: ____ Date: ____________________

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Notice of Privacy Practices Acknowledgement Form

Patient Name: ____ Date : ___________________

We will never share your personal or private information with other without your consent.

We may only disclose information about you in the following ways:

- To another healthcare provider, hospital or facility if they request it in order to assist them in caring for you.
- To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.
- If you are not available to receive an appointment reminder, a message may be left on your messaging service (voicemail) or with a person in your household or at work. We may also send you correspondence by email and/or text message.

My signature acknowledges I have read this notice, understand it and agree with the policies explained.

____ ___________________

Patient's Signature Date