Rockwall Elite Healthcare
*105 N Goliad St * Rockwall, TX * 75087*
972-961-0673

NEW PATIENT INFORMATION

Name:
_____Date:_____

DOB:_____Age:_____ Gender:_____ social security#_____-_____-_____

Address:_____

City:_____ State:_____ Zip code:_____

Home Phone: _____ Cell Phone:_ _____

Circle one: Married Single Widowed

Name of Spouse:_____ Spouses DOB:_____

Insurance Provider:_____ Member ID#:_____

What is the reason for your visit today?
_____

Have you been treated for this condition before? Yes No

If so When? How?
_____

Results_____

Is this a result from an accident or injury? Yes No Auto accident? Yes No

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How did you hear about us?

_____

If not a referral, Why did you choose this office?

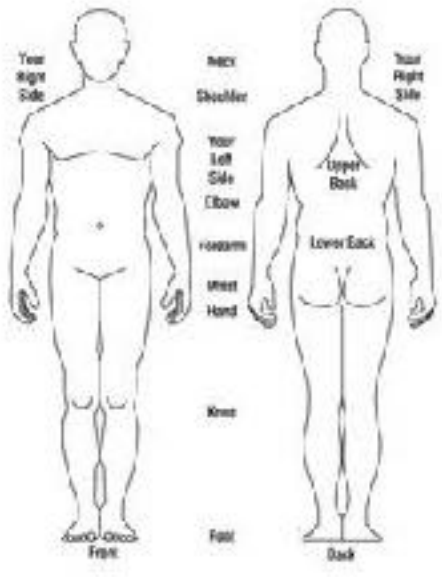
_____ ***Below to be filled out by office personal:***

Patient information entered into computer		Demo/ins	Yes	No
Insurance verified		N/A	Yes	No
Diagnosis codes entered			Yes	No
Treatment plan on file			Yes	No

PATIENT INTAKE FORM

Patient Name:_____ Date:_____

1. **Draw on the diagram below where you have pain/symptoms**



2. **How often do you experience your symptoms? (Circle most accurate)**

Constantly (76-100% of the time) Frequently (51-75% of the time)

Occasionally (26-50% of the time) Intermittently (1-25% of the time)

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3. **How would you describe your type of pain? (Circle most accurate)**

   Sharp Deep Ache Burning Shooting Numb/ness

   Stiff Tingly Dull Radiating up/down where?_____

4. **What have you found makes it better or worse, if anything?**

   _____

5. **Are your symptoms getting worse, better, or staying the same? (Circle most accurate)**

6. **Using a scale form 0-10 (10 being the worst), how would you rate your problem?**

7. **0 1 2 3 4 5 6 7 8 9 10**

8. **Has the problem interfered with your work? If so specify severity.**

Not at all A little bit Moderately Quite a bit Extremely

9. **Has your problem interferd with your social/family activities?**

   Not at all A little bit Moderately Quite a bit Extremely

10. **Who else have you seen for your problem? (Circle most accurate)**

    ER physician Neurologist Primary Care Physician Orthopedist

    Other Chiropractor Massage Therapist Other_____

11. **How long have you had this problem? _____**
12. **What do you think caused this problem? _____**
13. **Does it prevent you from doing any activities? _____**

    _____

14. **What type of exercise would you say you do? (Circle most accurate)**

    Strenuous Moderate Light None

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15. Indicate if you, or your immediate family members have any of the following:

Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

16. For each of the conditions listed below please circle if you have experienced them in the last six months:

Neck Pain	Diabetes	High Blood Pressure
Headaches	Chest Pains	Loss of Bowel or Bladder
Upper Back pain	Heart Attack	Cancer
Low Back Pain	Diabetes	Asthma
Shoulder Pain	Stroke	Visual Disturbances
Elbow Pain	Angina	Dizziness
Upper Arm Pain	Kidney Stones	Ringing in the ears
Wrist Pain	Abdominal Pain	**FEMALES ONLY:**
Hand Pain	Gall Bladder Disorder	**When was your last period?** _____
Hip Pain	Constipation	**Are you pregnant?**
Leg Pain	Excessive Thirst	**Yes No Not sure**
Ankle/Foot Pain	Sexual Dysfunction	
Jaw Pain	Joint Pain/Stiffness	

DO NOT WRITE BELOW THIS LINE

DIAGNOSIS
PATIENT ACCEPTED: YES NO REFERRED

PLEASE CIRCLE ONE TO BETTER HELP US REACH YOUR GOALS

RELIEF CARE (relieving of symptoms).

CORRECTIVE CARE (relieving of symptoms and addressing the CAUSE of the problem to decrease the recurrence of the problem).

I would like the doctor to give me his recommendations.

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Patient Signature:_____ Date: _____

Please take a moment to look through our patient testimonials in our waiting area that our patients have shared with us about their experience here at Rockwall Elite Healthcare. We look forward for the opportunity to seeing how we can help you!