



AUBURN CHIROPRACTIC

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PATIENT INTAKE FORM

Full Name: _____ Birth Date: _____ Gender: M F
Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ - _____ - _____ Phone#(Cell) _____ (H) _____
(W) _____ Email Address: _____

Your Employer: _____ Your Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip Code: _____

Marital Status: S M D W Sep Spouse's Name: _____ Birth Date: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Names and ages of children: _____

Primary Care Physician (PCP): _____ PCP Phone#: _____

Insurance — please allow our staff to photocopy your current health insurance card(s)

Name of Insurance: _____ ID# _____ Group#: _____

Name of Insured: _____ Insured's DOB: _____

Insured's Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Employer: _____ Relationship to Insured: _____

*Other Insurance: _____ ID#: _____ Group#: _____

Name of Insured: _____ Insured's DOB: _____

Insured's Address: _____ City: _____ State: _____ Zip Code: _____

Who may we thank for referring you to our office? _____

How did you hear about our office? _____

Your Health Profile

Is your current condition the result of: () an auto accident? () a work related accident? Date of Injury? _____

Have you had previous chiropractic care? Y N If yes, what was the doctor's name? _____

What was the date of your last visit? _____ What was the duration of your care? _____

Primary Complaint: _____

Secondary Complaint(s): _____

When and how did you experience this problem?

Primary complaint: _____

Secondary complaint: _____

When is this problem most severe? Primary complaint: _____

Secondary complaint: _____

How often do you experience this problem?: () 1-2x/week () 3-4x/week () 5-6x/week () daily () other _____

Please grade the intensity of this problem. (Please make an X on the line to designate your answer):

At best: Mild _____ Severe

At worst: Mild _____ Severe

How would you describe the symptoms (ie burning, stabbing, aching, sharp, etc.) _____

Does this problem cause pain to any other areas?: Y N If yes, where? _____

Is this problem getting: () Worse () Better () Staying the same?

What seems to aggravate this problem?: _____

Are there any activities of daily living that are difficult?: _____

What have you tried to relieve this problem? (ie interventions, treatments, aspirin, medications, surgery)?

Have you seen any other doctor's for this problem?: Y N If yes, who? _____

What treatment was given?: _____

How effective was the care?: _____

Current Medication:

Reason for taking:

Do you have any family or past history of medical problems? _____

-Date of last menstrual cycle: _____ -Are you taking birth control pills?: Y N -Are you pregnant at this time? Y N

Consent for Treatment and Payment Authorization:

-I, the undersigned, authorize payment of medical benefits to this office.

-I authorize the Doctors of Auburn Chiropractic, P.A., and whomever they designate as their assistants, to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to me. I am aware of any risk involved with my treatment in this office.

-I understand that due to increasing costs associated with medical billing, any outstanding patient balances greater than 90 days old will be forwarded to Thomas Agency for collection.

Patient's Signature: _____ Date: _____

Consent for Treatment of a Minor: (If applicable)

I hereby authorize the Doctors of Auburn Chiropractic, P.A., and whomever they designate as their assistants, to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to my (indicate relationship of child) _____, (child's name)