***Whom may we thank for referring you to this office 🡪 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?***

|  |  |
| --- | --- |
| A picture containing drawing  Description automatically generated | **8221 NE HAZEL DELL AVENUE #103**  **VANCOUVER, WA 98665**  [**www.tristarchiro.com**](http://www.tristarchiro.com)  [**tristarfamilychiropractic@gmail.com**](mailto:tristarfamilychiropractic@gmail.com)  **P: 360-258-1506  F: 360-828-1323 Text Line : 541-946-3815** |

**NEW ADULT PATIENT CARE FORM**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female 🞏 Other

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **❑** Single **❑** Married Do you have Insurance: **❑** Yes **❑** No Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification/Driver’s License #: (copy of ID will be made at time of appointment)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Children and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fourth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its **worst**? 🞏 AM 🞏 PM 🞏 mid-day 🞏 late PM

How long does it last? 🞏 It is constant **OR** 🞏 I experience it on and off during the day **OR** 🞏 It comes and goes throughout the week

Is your problem the result of ANY type of accident? 🞏 Yes 🞏 No **If yes,** circle one: WORK ACCIDENT CAR ACCIDENT SPORTS OTHER

**C**ondition(s) ever been treated by anyone in the past? 🞏Yes 🞏 No **If yes,** when: \_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long were you under care: \_\_\_\_\_\_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞏 N/A**

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

***R = R****adiating* ***B******= B****urning* ***D =******D****ull* ***A =*** *Aching* ***N = N****umbness* ***S =******S****harp/* ***S****tabbing* ***T= T****ingling*

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL USUAL ACTIVITY LEVEL**

***EXAMPLE: Walking ¼ Mile 2 Miles***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Office Use: Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_****\_\_/\_\_\_/\_\_\_*  ***JDD,DC 5/2011***

Identify any other injury(s) to your spine, minor or major, including childhood traumas that the doctor should know about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? \_\_\_\_\_\_\_\_ \_ When was the last episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did the injury happen?\_\_\_\_\_\_\_\_\_\_\_\_ Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

Other forms of treatment tried: 🞏 No 🞏 Yes **If yes,** please state **what** type of treatment you have tried:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whoprovided it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long ago? \_\_\_\_\_\_\_**What were the results. 🞏 Favorable 🞏 Unfavorable🡪 please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify any and all types of jobs/hobbies you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with the following

***P***for in the ***Past*, *C*** for ***Currently*** haveand ***N*** for *N****ever*** *have had***:**

\_**\_\_** Fracture**/**Broken Bone \_**\_\_**Dislocations **\_\_\_** Tumors \_**\_\_**Rheumatoid Arthritis **\_\_\_**Disability \_\_\_Cancer

\_\_\_ Heart Attack \_\_\_Osteo Arthritis \_\_\_Diabetes **\_\_\_**Cerebral Vascular/Stroke **\_\_\_** Other serious conditions:

**PLEASE identify** **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

|  |
| --- |
| **HOW LONG AGO TYPE OF CARE RECEIVED BY WHOM** |
| **INJURIES 🡪** |
| **SURGERIES 🡪** |
| **CHILDHOOD DISEASES🡪** |
| **ADULT DISEASES 🡪** |

**SOCIAL HISTORY**

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes 🡪 How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**2. Alcoholic** **Beverage**: consumption occurs 🡪 ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**3. Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

Do you have a Current Physician Issues Medical Marijuana Card? 🞏 No 🞏 Yes

**4. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**:

**1.** Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

**If yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister’s ❑ brother’s ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don’t know

**2. Any** other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment to be made directly to ***Tristar Family Spine and Wellness Center***, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ***Tristar Family Spine and Wellness Center*** for any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Patient or Authorized Person’s Signature Date Completed**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_**

**Doctor’s Signature Date Form Reviewed**

***Office Use: Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_****\_\_/\_\_\_/\_\_\_*  ***JDD,DC 5/2011***

***TRISTAR FAMILY CHIROPRACTIC, A Family Wellness Center***

**ACTIVITIES OF LIFE**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES: EFFECT: **\_\_\_\_\_\_\_\_**

Driving 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Extended Computer Use 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Household Chores 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Static Sitting (long periods) 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Static Standing(long periods) 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Lifting Children 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Reading/Concentration 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Washing/Bathing 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Dressing 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Shaving 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Grooming/Personal Care 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Carrying Groceries 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) ❑ Unable to Perform

Sit to Stand 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Climbing Stairs 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Pet Care 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Sexual Activities 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Sleep 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Exercise 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Walking 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Washing/Bathing🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Sweeping/Vacuuming 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Dishes 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Laundry 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Garbage 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

**Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_/\_\_\_/\_\_\_**

**Office Use: Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**\_\_/\_\_\_/\_\_\_  **JDD,DC 5/2011**

**Please mark P** for in the **Past, C** for **Currently** haveand **N** for **Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma

\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problem \_\_\_ Difficulty Breathing

\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems

\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritable \_\_\_ Bed Wetting \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disabilty \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

\_\_\_Cancer: Breast/Liver/Thyroid/Prostate/Cervical/Skin \_\_\_ Other :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Supplements, Prescription & Non-Prescription drugs you take**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other information you would like the doctor to know**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JDD,DC 5/2011

**Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_/\_\_\_/\_\_\_**

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*New adult patient intake form 9/2020*