HOWILL CHIROPRACTIC & WELLNESS

New Patient Intake (Print)

Fill this form at home and bring it to your visit. Do not email or upload completed forms — they contain health information. Arrive about 15 minutes early.

Richardson: 1651 N Collins Blvd Ste 124, Richardson, TX 75080
Arlington: 2000 East Lamar Blvd #600, Arlington, TX 76006
Phone: (214) 484-2629 · Hours: Mon–Fri 9 AM–5 PM
Clinic Director: Dr. Hung Manh Cao, D.C. · TX #199019

Privacy: This paper form is for clinic use only. Howill does not collect protected health information through the public website or Calendly. A secure online intake option is planned; until then, complete this form and bring it with you.

1. Demographics

LEGAL FIRST NAME _____ MIDDLE _____ LAST NAME _____

PREFERRED NAME _____ DATE OF BIRTH (MM/DD/YYYY) _____ SEX / GENDER (AS YOU PREFER TO LIST) _____

MARITAL STATUS _____ OCCUPATION _____ EMPLOYER (OPTIONAL) _____

2. Contact

STREET ADDRESS _____ APT / SUITE _____

CITY _____ STATE _____ ZIP _____

MOBILE PHONE _____ HOME / OTHER PHONE _____ EMAIL _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ EMERGENCY PHONE _____

☐ OK to leave a voicemail ☐ OK to text appointment reminders ☐ OK to email non-clinical messages

3. Visit reason & accident information (if any)

If this visit is not related to a motor vehicle collision, write “N/A” in the accident fields.

MAIN REASON FOR TODAY’S VISIT _____ DATE SYMPTOMS BEGAN _____

WAS THIS RELATED TO A CAR / AUTO ACCIDENT? _____ ACCIDENT DATE _____ CITY / STATE OF ACCIDENT _____

YOUR ROLE (DRIVER / PASSENGER / OTHER) _____ AUTO CLAIM NUMBER (IF KNOWN) _____ AUTO INSURER NAME _____

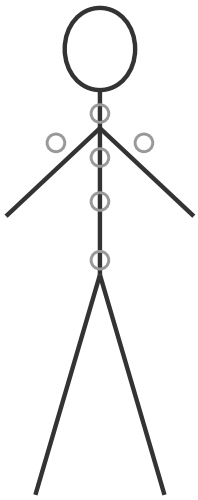
POLICE REPORT NUMBER (IF ANY) _____ DID YOU GO TO ER / URGENT CARE? _____ ATTORNEY NAME (OPTIONAL) _____

☐ I have PIP and/or MedPay on my auto policy (if known) ☐ I plan to use health insurance ☐ I plan to self-pay

4. Symptoms & pain diagram

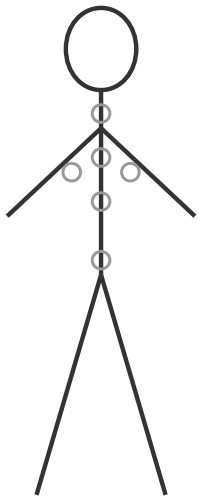
Mark areas of pain or discomfort. Circle one number for overall intensity today (0 = none, 10 = worst imaginable): 0 1 2 3 4 5 6 7 8 9 10

FRONT



Mark with X or shade

BACK



Mark with X or shade

WHAT MAKES IT BETTER?

WHAT MAKES IT WORSE?

Symptoms (check all that apply): ☐ Pain ☐ Stiffness ☐ Numbness / tingling ☐ Weakness ☐ Headache ☐ Dizziness ☐ Other: _____

5. Health history

Condition / history	Yes / No / Notes
Prior chiropractic care	
Prior imaging (X-ray, MRI, CT) for this problem	
Surgery (spine, joints, other)	
Fractures or major trauma	
Heart disease, stroke, blood pressure concerns	
Cancer (past or present)	
Diabetes	
Osteoporosis / bone density concerns	
Pregnancy (current or possible)	
Other conditions your provider should know	

ALLERGIES (MEDICATIONS, LATEX, SHELLFISH, OTHER)

6. Medications & supplements

Name	Dose / how often	Reason (optional)

☐ I take no medications or supplements

7. Acknowledgments & signatures

Please read each statement. Ask the front desk if you have questions before signing. Signing does not waive any rights under HIPAA. A full Notice of Privacy Practices is available at the clinic.

☐ I understand the information on this form is true to the best of my knowledge and that care recommendations depend on an in-person exam.

☐ I acknowledge that I have been offered Howill's Notice of Privacy Practices (HIPAA) and may request a paper copy at any time.

☐ I understand Howill does not promise specific results, and that I may decline any recommended care.

☐ I understand billing options (self-pay, health insurance, and when applicable PIP or MedPay) will be explained before care begins. Howill does not give legal advice.

PATIENT SIGNATURE _____ DATE _____

PRINTED NAME _____ DATE OF BIRTH _____

PARENT / GUARDIAN SIGNATURE (IF PATIENT IS UNDER 18) _____ DATE _____

PARENT / GUARDIAN PRINTED NAME _____ RELATIONSHIP _____