



# NEW PATIENT INTAKE FORM

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
LAST NAME

Employer / School \_\_\_\_\_

Occupation \_\_\_\_\_

Address \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL

Spouse's Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Home Phone \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Cell Phone \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_ Birthday \_\_\_\_\_

Relationship \_\_\_\_\_

Married  Widowed  Single  Minor

Contact Number \_\_\_\_\_

Separated  Divorced  Partnered

Who may we thank for referring you? \_\_\_\_\_

## HOW CAN WE HELP YOU?

What brings you in today? \_\_\_\_\_

If you are already experiencing a symptom, what is it? \_\_\_\_\_

How bad is it? How intense are your symptoms? (circle)

0    1    2    3    4    5    6    7    8    9    10  
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

<input type="checkbox"/> Numbness	<input type="checkbox"/> Sharp
<input type="checkbox"/> Tingling	<input type="checkbox"/> Shooting
<input type="checkbox"/> Stiffness	<input type="checkbox"/> Burning
<input type="checkbox"/> Dull	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Aching	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Cramping	<input type="checkbox"/> Swelling
<input type="checkbox"/> Nagging	<input type="checkbox"/> Other _____

## IMPACT OF YOUR SYMPTOMS

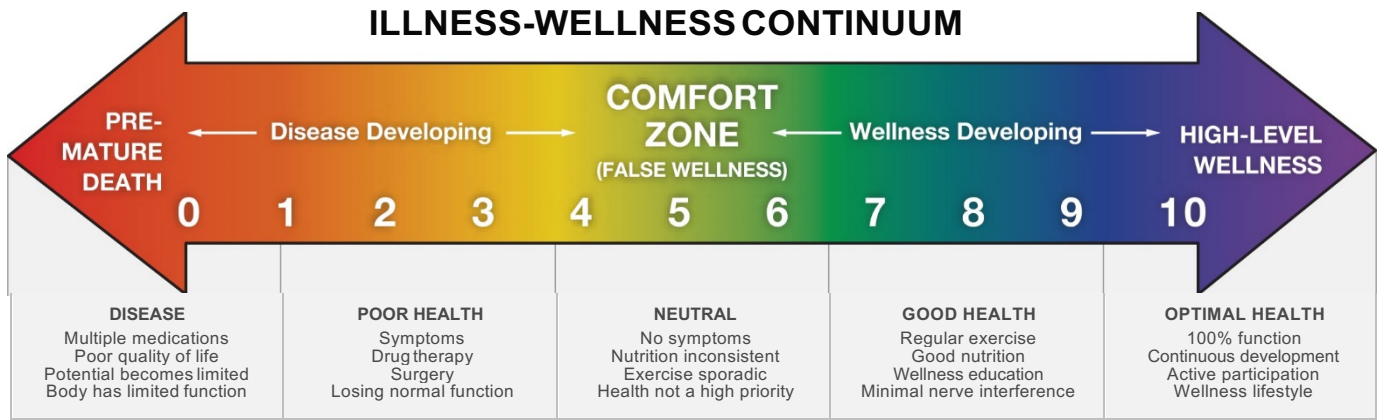
How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0    1    2    3    4    5    6    7    8    9    10  
NOT COMMITTED VERY COMMITTED

# PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? \_\_\_\_\_

B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONGTERM \_\_\_\_\_

## CHILDREN AND PREGNANCY

How many children do you have? \_\_\_\_\_

Are you currently pregnant?  No  Yes, I am due \_\_\_\_\_

Childrens' names & ages? \_\_\_\_\_

Number of past pregnancies? \_\_\_\_\_

Childrens' health concerns? \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues                                   | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears      |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness                                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shoulder Issues      |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hip Issues            | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Arthritis/Rheumatoid  | <input type="checkbox"/> Digestive Issues<br>(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues         | <input type="checkbox"/> TMJ Issues           |
| <input type="checkbox"/> Asthma/Allergies      | <input type="checkbox"/> Elbow/Wrist/Hand Issues                              | <input type="checkbox"/> Lymphatic Issues      | <input type="checkbox"/> Urinary Issues       |
| <input type="checkbox"/> Back/Neck Pain        | <input type="checkbox"/> Endocrine Issues (Thyroid)                           | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Fracture/Broken bone |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues                                    | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Genetic Disease                                      | <input type="checkbox"/> Reproductive Issues   | _____   |

## ALLERGIES, MEDICATIONS & SURGERY

ALLERGIES (list) \_\_\_\_\_

MEDICATIONS/CONDITIONS (list) \_\_\_\_\_

SURGERY (list) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:**

Does anyone in your family been diagnoses with:  Heart Disease  High Blood Pressure  Kidney Disease  Lung Disease  Diabetes  High Cholesterol  Asthma  Cancer  Stroke  Alzheimer's/dementia  Osteoporosis  Genetic Disorder

Please list child, spouse, sibling, mother, and/or father and diagnosis: \_\_\_\_\_

**EXPERIENCE WITH CHIROPRACTIC:**

Have you seen a Chiropractor before?  Yes  No Reason for visits: \_\_\_\_\_

Favorable outcomes?  Yes  No Explain: \_\_\_\_\_

Are you aware of any of your poor posture habits?  Yes  No Explain: \_\_\_\_\_

Are you aware of any poor posture habits in your spouse or children?  Yes  No Have their spines been checked?

Explain: \_\_\_\_\_

**HEALTH LIFESTYLE:**

Were you injected with a COVID Vaccine?  Yes  No How many boosters? 1X 2X 3X 4X 5X

Do you exercise?  Yes  No How often? 1X 2X 3X 4X 5X per week other: \_\_\_\_\_

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much / week? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

**ACKNOWLEDGMENTS: Please read each statement and initial your agreement on the left.**

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: (MM/DD/YYYY) \_\_\_\_\_

**Consent to Spinal Imaging**

I hereby grant Vertical Chiropractic permission to perform an x-ray evaluation of my spine if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

**Insurance Information**

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

**Privacy Policy**

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

**Appointment Reminders and Health Care Information Authorization**

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

**By signing below, you are acknowledging that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity, or cause of your health concern.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please make sure you completed this form neatly, accurately, and completely.