**Patient Name: _____**

# PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of Central Chiropractic. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

## PATIENT DETAILS

**First Name**: _____ **Last Name**: _____

**Date of Birth**: _____ **Gender**: ☐ Male ☐ Female ☐ Other

**Street Address**: _____

**City**: _____ **State**: _____ **ZIP Code**: _____

**Home Phone**: _____ **Mobile Phone**: _____

**E-Mail**: _____

**Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

**Spouse Name**: _____ **Spouse Phone**: _____

## EMERGENCY CONTACT

**Emergency Contact Name**: _____

**Relationship**: _____ **E-Mail**: _____

**Home Phone**: _____ **Mobile Phone**: _____

**Patient Name: _____**

## PHYSICIANS

**Primary Care Physician**: _____

**Clinic Name**: _____

**Street Address**: _____

**City**: _____ **State**: _____ **ZIP Code**: _____

**Mobile Phone**: _____ **Fax**: _____

## ALLERGIES

List your allergies and describe the reactions to your body:

**Allergy**: _____ **Reaction**: _____
**Allergy**: _____ **Reaction**: _____
**Allergy**: _____ **Reaction**: _____
**Allergy**: _____ **Reaction**: _____

## MEDICATION

List the medications you are currently taking including the dosage:

**Medication**: _____ **Dose**: _____
**Medication**: _____ **Dose**: _____
**Medication**: _____ **Dose**: _____
**Medication**: _____ **Dose**: _____

## FAMILY HEALTH HISTORY

List any major conditions/illnesses that your immediate family members have had:

| Relative | Condition | Living? | If deceased, at what age? |
|---|---|---|---|
| Mother | | ☐ Y ☐ N | |
| Father | | ☐ Y ☐ N | |
| Sibling | | ☐ Y ☐ N | |
| Other: | | ☐ Y ☐ N | |
| Other: | | ☐ Y ☐ N | |

**Patient Name: _____**

## SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

| Description | Doctor | Location | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## MEDICAL HISTORY

Have you ever had any of the following?

| | | | |
|---|---|---|---|
| Anemia | ☐ Y ☐ N | Hypertension | ☐ Y ☐ N |
| Arthritis Conditions | ☐ Y ☐ N | Male Hypogonadism | ☐ Y ☐ N |
| Asthma | ☐ Y ☐ N | Hypothyroidism | ☐ Y ☐ N |
| Atrial Fibrillation | ☐ Y ☐ N | Infection Problems | ☐ Y ☐ N |
| Bleeding Problems | ☐ Y ☐ N | Insomnia | ☐ Y ☐ N |
| Benign Prostatic Hyperplasia | ☐ Y ☐ N | Irritable Bowel Syndrome | ☐ Y ☐ N |
| Coronary Artery Disease | ☐ Y ☐ N | Kidney Problems | ☐ Y ☐ N |
| Cancer | ☐ Y ☐ N | Menopause | ☐ Y ☐ N |
| Cardiac Arrest | ☐ Y ☐ N | Migraines/Headaches | ☐ Y ☐ N |
| Celiac Disease | ☐ Y ☐ N | Neuropathy | ☐ Y ☐ N |
| Chest Pain | ☐ Y ☐ N | Onychomycosis | ☐ Y ☐ N |
| Congestive Heart Failure | ☐ Y ☐ N | Organ Injury | ☐ Y ☐ N |
| Chronic Fatigue Syndrome | ☐ Y ☐ N | Osteoporosis | ☐ Y ☐ N |
| Depression | ☐ Y ☐ N | Pulmonary Embolism | ☐ Y ☐ N |
| Diabetes | ☐ Y ☐ N | Seizure Disorders | ☐ Y ☐ N |
| Drug/Alcohol Abuse | ☐ Y ☐ N | Shortness of Breath | ☐ Y ☐ N |
| Erectile Dysfunction | ☐ Y ☐ N | Sinus Conditions | ☐ Y ☐ N |
| Fibromyalgia | ☐ Y ☐ N | Stroke | ☐ Y ☐ N |
| Gerd | ☐ Y ☐ N | Syndrome X | ☐ Y ☐ N |
| Heart Disease | ☐ Y ☐ N | Tremors | ☐ Y ☐ N |
| Hyperinsulinemia | ☐ Y ☐ N | Wheat Allergy | ☐ Y ☐ N |
| Hyperlipidemia | ☐ Y ☐ N | | |

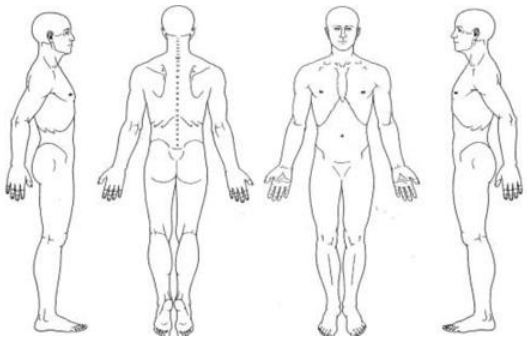
List any other medical problems that you have had:

**Patient Name:** _____

## HEALTH CONCERNS

**Check any of the following that describe your pain and circle any pain:**

| | | | |
|---|---|---|---|
| Aching | ☐ | Numbness | ☐ |
| Sharp | ☐ | Throbbing | ☐ |
| Spasming | ☐ | Squeezing | ☐ |
| Stabbing | ☐ | Tingling | ☐ |
| Cramping | ☐ | Shock-like | ☐ |
| Dull | ☐ | Shooting | ☐ |
| Hot/Burning | ☐ | Other | ☐ |



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**What's your primary health concern?** _____

**Approximately when did this issue begin?** _____
**How has the pain changed since it began?** ☐ Increased ☐ Decreased ☐ Unchanged
**How quickly did your current pain begin?** ☐ Gradually ☐ Suddenly
**How often does your pain occur?** ☐ Constantly ☐ Occasionally ☐ Rarely

**Please rate your pain at it best (circle), its average (square), and at its worst (star).**


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**What's your Secondary health concern?** _____

**Approximately when did this issue begin?** _____
**How has the pain changed since it began?** ☐ Increased ☐ Decreased ☐ Unchanged
**How quickly did your current pain begin?** ☐ Gradually ☐ Suddenly
**How often does your pain occur?** ☐ Constantly ☐ Occasionally ☐ Rarely

**Please rate your pain at it best (circle), its average (square), and at its worst (star).**

**Patient Name: _____**

## SOCIAL HISTORY

**Do you currently consume alcohol?** ☐ Yes ☐ No

- How many drinks per week? _____

**Do you currently smoke?** ☐ Yes ☐ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

**Do you currently use any other drugs?** ☐ Yes ☐ No

- What other drugs do you take? _____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

**Do you drink caffeine?** ☐ Yes ☐ No

- How many cups per day? _____

**How frequently do you exercise?** ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

**Are you on a special diet?** ☐ Yes ☐ No

- What diet? _____

## EXTRA NOTES

**Please add any additional information that you think is relevant:**

**Patient Name: _____**

## PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

**Consent for Treatment and Release of Liability**
I consent to receive care from Central Chiropractic, including chiropractic adjustments, massage therapy, physical therapy techniques, and exercise instruction. I understand that outcomes are not guaranteed.
I acknowledge the risks of treatment, which may include soreness, sprains, dislocations, fractures, and in rare cases, stroke. I accept these risks and release Central Chiropractic, its staff, and providers from liability, except in cases of gross negligence or willful misconduct.

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**Patient Rights, HIPAA, and Communication**
I certify the information I provide is accurate and complete.
I acknowledge that Central Chiropractic maintains a Notice of Privacy Practices (HIPAA), which I have the right to review.
I authorize the release of my health information as needed for coordination of care, referrals, insurance billing, and records requests. Central Chiropractic will protect my information as required by law.
I consent to receive communications (e.g., appointment reminders, test results) via phone, voicemail, text, and email.

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**Financial Agreement and Insurance Disclaimer**
I understand that I am financially responsible for all services provided, regardless of insurance coverage. Central Chiropractic may bill my insurance as a courtesy, but this does not guarantee payment.
I agree it is my responsibility to understand my insurance coverage, including visit limits, deductibles, and exclusions. I agree to pay any portion not covered by insurance, including denied claims and non-covered services. Unpaid balances may incur late fees or be sent to collections.
Medicare Patients: I understand that Medicare does not cover exams, re-exams, or non-spinal-manipulation services. I accept full financial responsibility for any such charges**.**

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**24-Hour Cancellation & No-Show Policy**
Appointments are reserved for you. We require at least 24 hours' notice to cancel or reschedule.
Missed appointments or cancellations with less than 24 hours' notice will result in a $50 fee per incident. This applies to both chiropractic and massage appointments.

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**Patient Signature: _____ Date: _____**

If patient is a minor:
**Parent/Guardian Name: _____**
**Signature: _____ Date: _____**