VERTICAL® CHIROPRACTIC

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

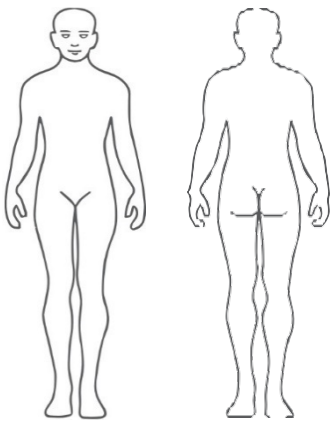
If you are already experiencing a symptom, what is it? _____

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)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ 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	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

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? _____

Childrens' names & ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

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

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

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)? _____

ACKNOWLEGMENTS: 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.