VITALITY chiropractic FAMILY PRACTICE

New Patient Intake Form

Fill out form digitally and submit form email back to vitalitychiropracticsarasota@gmail.com or print and bring in to our appointment.

Name: _____

Address: _____

_____

City: _____

Phone: _____

Email: _____

SSN: _____

Todays Date: _____

Attorney Name: (accident) _____

How did you hear about us?

Search Engine _____

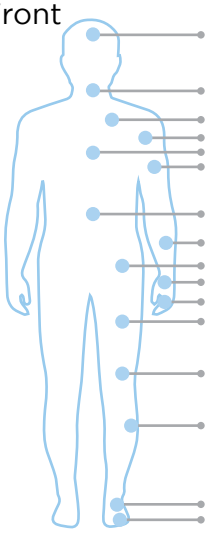
Social Media _____

Referral _____

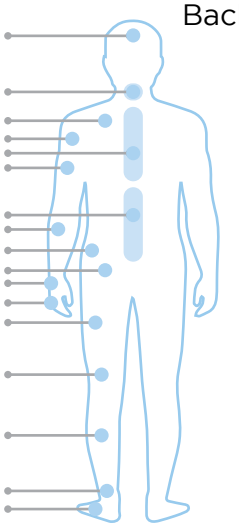
Other _____

CHIEF COMPLAINT

Front



Back



Please check off all areas of concern

Neck Pain ○ Headaches ○ Mid-Back Pain ○ Lower Back Pain ○

Left Arm ○ Left Leg ○ Left Shoulder ○ Other _____

Right Arm ○ Right Leg ○ Right Shoulder ○

Onset Date _____ Gradual ○ Sudden ○

Pain Radiates From _____ TO _____

What makes it better? _____

What makes it worse? _____

Quality of Pain? ○ Sharp ○ Dull ○ Achy ○ Burning ○ Deep

Other _____

Worse in: ○ Morning ○ Afternoon ○ Night ○ Same all Day

Pain Level: 1 = Better 10 = Worse _____

Is this injury an auto accident? ○ Yes ○ No

Occupation _____

Describe your stress level? 1 = Low 10 = High _____

Health History

Please check any conditions that you have been diagnosed with

- ○ Abdominal pain
- ○ Arthritis
- ○ Bloody stool
- ○ Bruise easily
- ○ Chest pain
- ○ Constipation
- ○ Depression
- ○ Diarrhea
- ○ Difficulty Breathing
- ○ Dizziness
- ○ Ear Ache
- ○ Eye Problems
- ○ Fatigue
- ○ Fever
- ○ Headaches
- ○ Hypertension
- ○ Kidney Stone
- ○ Liver Disease
- ○ Loss of Sleep
- ○ Low Blood Pressure
- ○ Mental Illness
- ○ Nausea
- ○ Tremors
- ○ Weight Loss

Family History

Please check any conditions that you or any blood relative has been diagnosed with

- ○ Arthritis
- ○ Autoimmune Disease
- ○ Cancer
- ○ Diabetes
- ○ Heart Disease
- ○ High Cholesterol
- ○ Hypertension
- ○ Neurological Disorder
- ○ Osteoporosis
- ○ Respiratory Disease
- ○ Stroke
- ○ Thyroid Disease

Social History

Please fill out the social questionnaire to your best abilities.

Sexually Active? ○ Yes ○ No

Do you Smoke? ○ Yes ○ No ○ Use to

How many per day? _____

Average hours of sleep per night? _____

Do you rise feeling rested? ○ Yes ○ No

Do you exercise? ○ Yes ○ No

How many days a week _____ Duration _____

Do you do any recreational drugs? ○ Yes ○ No

What kind? _____

Do you drink alcohol? ○ Yes ○ No

How many days a week _____ Quantity _____

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Medical History

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Medical History

List all the surgeries, hospitalizations and injuries you have had and the date:

_____

_____

List all the medications you are talking:

_____

_____

Have you received Chiropractic care before? ◯ Yes ◯ No If yes, chiropractors name: _____

Reason for seeking care: _____

Do you have current x-rays: ◯ Yes ◯ No Last visit date: _____ Results: ◯ Good ◯ Fair ◯ Poor

Basic Nutrition

How would you rate your diet? 1 = unhealthy 10 = healthy _____

Have you ever been told you have High Cholesterol or Triglycerides? ◯ Yes ◯ No

Have you ever been diagnosed with High Blood Pressure? ◯ Yes ◯ No

Have you been diagnosed as Diabetic? ◯ Yes ◯ No

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? ◯ Yes ◯ No

How many days a week do you skip a meal? (3/meals/day) _____

How many "fast food", "redefined food", or "pre-prepared" meals do you eat per week? ◯ 0 ◯ 1-3 ◯ 4-6 ◯ 7+

How many servings of fruit do you eat per day? ◯ 0-1 ◯ 2-3 ◯ 4-5

How many servings of vegetables do you eat per day? ◯ 0-1 ◯ 2-3 ◯ 4-5

How many ounces of water you drink a day? (1 glass=8oz) _____

Do you regularly drink 1 or more per day of the following: (Check all that apply) ◯ Soda ◯ Diet Soda ◯ Coffee ◯ Juice ◯ Milk ◯ Alcohol

How many servings of redefined sugars do you eat per day? (Candy,Cookies,Cake, etc.) ◯ 0-1 ◯ 2-3 ◯ 4-5

Please list all nutritional supplements/vitamins you take regularly: (Staff can photocopy a list if you have one)

Supplement Name/Type	*Frequency*	*Brand or Where Purchased*

Cancellation Policy-Please Initial

_____I understand that if I cancel my appointment with less than 24 hours notice before it is scheduled I will be subject to a rebooking fee of $25.

Patient Signature (parent/guardian) _____ **Date:** _____

I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

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Consent to Care

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Submit

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT & CARE

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If this occurs, I will apply ice to the area (as instructed) and rest. If I am concerned about this discomfort or develop new symptoms, I can call the clinic phone number 24 hours a day and reach the doctor on call for emergency attention. If out of town, or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside this office (laboratory or other diagnostic procedure) I understand the doctor will notify me of the results when the report becomes available.
I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapy and if necessary, diagnostic radiographs (x-rays) by the doctor of chiropractic in this office or anyone in this office authorized by the doctor of chiropractic.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks with treatment, including but not limited to muscle strains and sprain, disc injures and strokes, I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intent this consent form to cove r the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Name (Please Print) _____ Signature _____ Date _____

Witness _____ Parent/Guardian _____ for minors

SUBMIT