



Adult Intake Form

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____

Address: _____

City/State/Zip: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Email: _____

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: _____ Spouse's Name: _____

of Children: _____ Children's Names & Ages: _____

Who can we thank for referring you or how did you hear about our office? _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Align Family Chiropractic? _____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

What is this affecting that is MOST important in your life? (List all that apply)

Have you seen a chiropractor before? YES NO

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for change? (if applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life? _____

HEALTH CONCERNS

- | | |
|---|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Digestive Troubles | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Loss of Concentration |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Stiffness/Flexibility |
| <input type="checkbox"/> Pain in Arms/Legs | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above or add additional

concerns: _____

Is there anything else regarding your current condition you feel the doctor should know? _____

MEDICATIONS

- | | |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other _____ | |

Explain any boxes checked above: _____

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



- Headaches
- Migraines
- Dizziness
- Sinus Problems
- Allergies
- Fatigue/Sleep Problems
- Head Colds
- Vision Problems
- Difficulty Concentrating
- Hearing Problems

- Sore Throat
- Stiff Neck
- Radiating Arm Pain
- Hand/Finger
- Numbness
- Asthma
- Allergies
- High Blood Pressure
- Heart Conditions

- Middle Back Pain
- Congestion
- Difficulty Breathing
- Bronchitis
- Pneumonia
- Gallbladder Conditions
- Stomach Problems
- Ulcers
- Gastritis
- Kidney Problems
- Indigestion

- Constipation
- Colitis
- Diarrhea
- Gas Pain
- Irritable Bowel
- Bladder Problems
- Menstrual Problems
- Low Back Pain
- Pain/Numbness in Legs
- Reproductive Problems

VITAMINS/SUPPLEMENTS

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Multivitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Explain any boxes checked above: _____

EMERGENCY CONTACT

First Name: _____ M.I. _____

Last Name: _____

Preferred Name: _____ Phone: _____

Address: _____

City/State/Zip: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor’s recommendations for care. Please keep your appointment as scheduled or call the office within 12 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- If more than two scheduled appointments are missed without a 12-hour notice, you may be subject to a cancellation fee.
- With the exception to Medicare, we are out of network with all insurance companies. It is your responsibility to pay in full after each visit.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special arrangements, we will do everything possible to meet your financial needs.

Patient Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstances. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Signature: _____ Date: _____
Parent or Guardian: _____ Date: _____
Witness Signature: _____ Date: _____