



New Patient Intake

Today's Date _____/_____/_____

Legal Full Name _____

Preferred Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Date of Birth _____/_____/_____ Age _____ Sex _____

How Did You Hear About Us? _____

Pronouns? He/Him She/Her They/Them Other: _____

Marital Status _____ Number of Children _____

Employment/Student Status _____ Occupation _____

When was your last visit to a chiropractor? (approx.) _____

How do you want us to handle your symptoms and health?

☐ Relief Care Only ☐ Maximum Correction ☐ Wellness Care ☐ Unsure

Emergency Contact Name _____ Phone _____

Relationship to Patient _____

If Patient is Under 18 years old

Parent/Guardian Full Name _____

Phone _____

Complaints (Location)	Intensity ☺ 1 - 10 ☹	Does it radiate?	Is the pain constant?	Start date?	What was the cause?	Is it getting better/worse?
1.	/10					better/worse/same
2.	/10					better/worse/same
3.	/10					better/worse/same

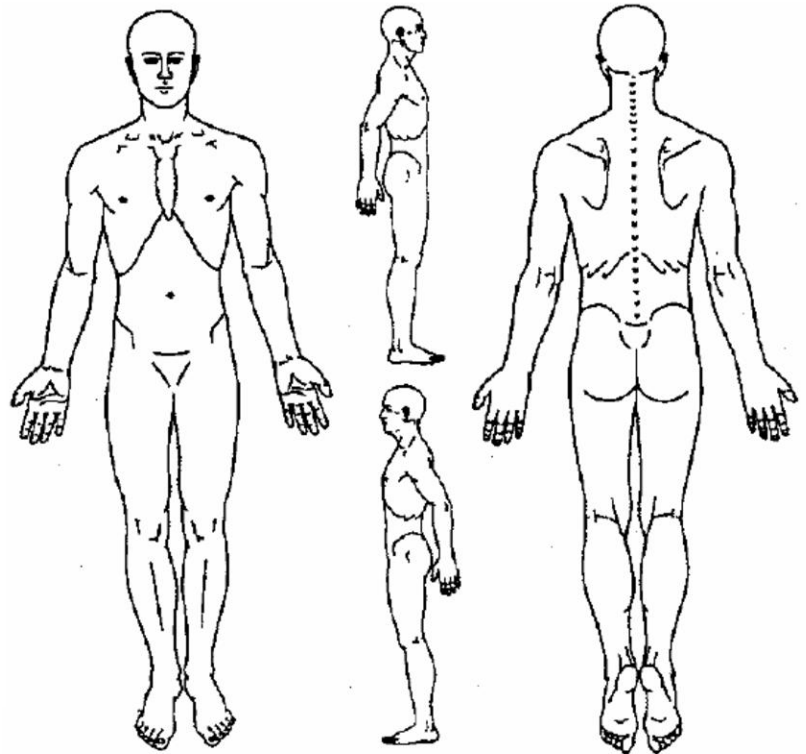
Please circle the area of injury or discomfort on the chart

What things aggravate the pain?

What things relieve the pain?

Describe the pain?

- | | |
|--|---------------------------------------|
| ☐ Dull | ☐ Burning |
| ☐ Achy | ☐ Weakness |
| ☐ Sore | ☐ Throbbing |
| ☐ Tightness | ☐ Cramping |
| ☐ Stiff | ☐ Sharp |
| ☐ Numb/Tingling | ☐ Other: _____ |
| ☐ Shooting | |
| ☐ Stabbing | |



Select all tasks that have become difficult to do since the start of this/these condition(s):

- | | | |
|-----------------------------------|--|---|
| ☐ Sleeping | ☐ Bending/Lifting | ☐ Using a computer |
| ☐ Sitting | ☐ Work | ☐ Recreation |
| ☐ Standing | ☐ Personal Care | |
| ☐ Walking | ☐ Driving/Traveling | |

For Doctors Notes Only

Range of Motion Test

Cervical

- Flexion ____/60 Px – Stiff – Rad – Tight
- Extension ____/55 Px – Stiff – Rad – Tight
- LLF ____/40 Px – Stiff – Rad – Tight
- RLF ____/40 Px – Stiff – Rad – Tight
- L R ____/80 Px – Stiff – Rad – Tight
- R R ____/80 Px – Stiff – Rad – Tight

MSR:

Lumbar

- Flexion ____/90 Px – Stiff – Rad – Tight
- Extension ____/30 Px – Stiff – Rad – Tight
- LLF ____/35 Px – Stiff – Rad – Tight
- RLF ____/35 Px – Stiff – Rad – Tight
- L R ____/30 Px – Stiff – Rad – Tight
- R R ____/30 Px – Stiff – Rad – Tight

Orthos:

Personal Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease: _____
- ☐ Blood Pressure Issues
- ☐ Bronchitis
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis
- ☐ Dental complaints
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastro-esophageal Reflux
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ IBS
- ☐ Infections (Chronic)
- ☐ Kidney Disease
- ☐ Learning disabilities
- ☐ Liver or Gall stones
- ☐ Mental Illness
- ☐ Migraines
- ☐ Neurological Problems
- ☐ Obesity
- ☐ Osteoporosis/Osteopenia
- ☐ S.A.D
- ☐ S.T.D
- ☐ Scoliosis
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infections
- ☐ Varicose Veins
- ☐ Other: _____

Family Health History

- ☐ Arthritis
- ☐ Alzheimer's
- ☐ Blood Pressure – high/low
- ☐ Cancer- type _____
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Infertility
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Neurological Disorders
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Thyroid
- ☐ Varicose Veins
- ☐ Others: _____

Surgery (Type and Year):

Car Accident:

Sports/work injury:

Social History

- ☐ Tobacco use Yes/No/Quit
☐ how often _____
- ☐ Alcohol Yes/No
- ☐ Diet/restrictions _____
- ☐ Allergies _____
- ☐ Exercise
☐ Type _____
- ☐ Duration _____
- ☐ Frequency _____

Female:

- ☐ Menstrual Irregularities
- ☐ Menopause
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibroids/ Ovarian Cysts
- ☐ Premenstrual syndrome
- ☐ Breast Cancer
- ☐ Pelvic Inflammatory disease
- ☐ Vaginal Infection
- ☐ Decreased Sex Drive
- ☐ Other _____
- ☐ Date of last GYN exam: ____/____/____
- ☐ Mammogram: +/-
- ☐ Form of Birth Control: _____

of pregnancies: _____

of children: _____

Vaginal/ C- Section

Are you pregnant or trying to
become pregnant?

Yes/No/NA

If yes, due date: ____/____/____

Male:

- ☐ Benign Prostatic Hyperplasia
- ☐ Decreased Sex Drive
- ☐ Infertility
- ☐ Other: _____

Children:

- ☐ Ear infection
- ☐ Colic
- ☐ Constipation/diarrhea or
other digestive issues
- ☐ Bed wetting/incontinence

Medications:

CONSENT TO CHIROPRACTIC & MASSAGE THERAPY

I understand that chiropractic care and massage therapy involve assessment and treatment of the body, including the spine, joints, muscles, and other soft tissues. Treatment may include, but is not limited to, chiropractic adjustments/manipulation (using hands or mechanical devices), massage and soft-tissue techniques, Graston, stretching and exercises, electrical stimulation, therapeutic ultrasound, hot or cold therapy, acupuncture, X-rays when indicated, and nutritional counseling or supplements.

I understand that treatment may cause temporary soreness, tenderness, bruising, tingling, or discomfort. Chiropractic treatment also carries uncommon but potentially serious risks, including, but not limited to, sprains, strains, fractures, disc injuries, dislocations, and stroke. I understand that no particular result or outcome is guaranteed and that other risks or side effects may occur.

If nutritional supplements are recommended, I understand that supplements may have side effects, interactions, or contraindications, including during pregnancy. Possible side effects may include nausea, gas, stomach upset, vomiting, headache, diarrhea, rash, hives, or tingling. I agree to notify the clinic if I become pregnant or if my health status changes in a way that may affect treatment.

I understand that delaying or declining appropriate treatment may allow my condition to persist or worsen and may make future rehabilitation more difficult.

I have had the opportunity to discuss the nature, purpose, benefits, risks, and alternatives to treatment and to ask questions. I understand that I may decline or withdraw consent for any treatment at any time.

MASSAGE THERAPY

Massage therapy involves assessment and treatment of muscles, soft tissues, and joints. The treatment plan will be discussed with me before treatment.

I understand and agree that:

- My treatment and health information will be kept confidential and securely maintained, except as permitted or required by law.
- I may undress only to my comfort level and will be appropriately draped. Only areas being treated will be exposed.
- I will communicate with my therapist regarding pressure, discomfort, pain, or any other concerns during treatment.
- I may request that treatment be modified or stopped at any time, regardless of prior consent.
- The therapist may decline to treat a particular area or may refuse treatment when there is a reasonable cause.

APPOINTMENTS & MESSAGE FEES

Appointments are expected to begin on time. If I arrive late, my treatment time may be shortened and the scheduled fee will still apply.

Massage fees are due at the time of service. Payment may be made by cash, check, or credit/debit card.

Cancellations must be received at least 24 hours in advance. Appointments cancelled with less than 24 hours' notice may be subject to a cancellation fee.

FINANCIAL & INSURANCE POLICY

I understand that I am personally responsible for payment of all services provided, regardless of whether my insurance pays for the services.

Auto Accidents: I am responsible for notifying my insurance company/agent that I am receiving care and completing any required claim or benefits forms. If applicable, deductibles are my responsibility unless other arrangements have been made.

Workers' Compensation: I am responsible for notifying my employer and completing any required workers' compensation paperwork. Coverage is subject to the applicable claim and insurance rules.

Medicare: Medicare coverage is limited and generally applies only to covered spinal manipulation services after applicable requirements and deductibles are met. Medicare does not generally cover services such as examinations, X-rays, physiotherapy, nutritional supplements, exercises, consultations, laboratory tests, or orthopedic exercises. An additional Medicare ABN may be required.

Major Medical/Other Insurance: Insurance companies may deny payment for services they determine are not reasonable and necessary under their policies. If insurance denies payment, I agree to be personally responsible for the balance due.

I authorize the clinic and my treating provider to release necessary information to my insurance company for purposes of processing claims. I assign applicable insurance benefits to Moe Chiro Tres PLLC and authorize payment of those benefits directly to the clinic.

I understand that copays, deductibles, coinsurance, and other patient-responsibility amounts are due at the time of service.

MASTER DISCLOSURES & SIGNATURE PAGE

Patient Name: _____

Date of Birth: ____/____/____

Acknowledgment and Consent

I acknowledge that I have been provided with, have read (or had read to me), and have had an opportunity to ask questions about the following disclosure and policy sections included in the Fit Family Chiropractic New Patient paperwork:

1. Informed Consent – Chiropractic Treatment
2. Financial Policy and Agreement
-Medicare Patients Only- ABN
3. Massage Therapy Informed Consent
4. Notice of Privacy Practices Acknowledgement and Additional Disclosure Policy

By signing below, I acknowledge and agree to the terms, risks, policies, consents, and authorizations contained in the disclosure sections listed above. I understand that this signature is intended to serve as my signature for those sections and for the entire course of treatment described in the paperwork, to the extent applicable. I understand that results are not guaranteed and that I may ask questions about any of these disclosures.

Additional Disclosure Authorization

We keep a record of the health care service we provide you. You may ask to see and copy your records. You can also ask to correct that record. We will not disclose your records to others unless the law authorizes or compels us to do so. You may see your records to get more information about it by contacting Moe Chiro Tres PLLC. Our Notice of Privacy Practices describes in more detail how your health information may be used, disclosed, and how you can access your information.

☐ No other spouse, family member or friend may have access to my health information.

☐ I authorize disclosures of my protected health information to:

Name: _____ **Relationship:** _____

Patient/Legal Guardian Printed Name: _____ **Date:** _____

Signature: _____

If Patient is under 18:

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Patient/Legal Guardian Printed Name: _____ **Date:** _____

Signature: _____