Patient Intake Form

Name: ______________________________ Date: ______________________
Address: ____________________________ Email: _____________________
Tel: ______________ Tel: (other) ______________ Date of birth: ________________
Occupation: ______________________ How did you find us? ___________________
Main interest for today's visit? ☐ Chiropractic ☐ Massage ☐ Orthotics ☐ Acupuncture ☐ Compression Stockings
Reason for seeking treatment: ______________ Is this your first massage or chiropractic treatment?☐Yes ☐No
Did a health care professional refer you for treatment? ☐Yes ☐No ______________________________

Cardiovascular
☐ High blood pressure
☐ Low blood pressure
☐ Chronic congestive heart failure
☐ Heart attack
☐ Phlebitis/varicose veins
☐ Stroke/CVA
☐ Pacemaker or similar device
☐ Heart disease

Is there a family history of any of the above? ☐Yes ☐No

Respiratory
☐ Chronic cough
☐ Shortness of breath
☐ Bronchitis
☐ Asthma
☐ Emphysema

Is there a family history of any of the above? ☐Yes ☐No

Infections
☐ Hepatitis
☐ Skin conditions
☐ TB
☐ HIV
☐ Herpes

Other Conditions
☐ Loss of sensation, where? ________
____
☐ Diabetes, type? ______________
☐ Allergies/hypersensitivity, to what?
Type of reaction: ______________
☐ Epilepsy
☐ Cancer, where? ______________
____
☐ Skin conditions, what? ________
____
☐ Arthritis

Is there a family history of arthritis?
☐Yes ☐No

Head/Neck
☐ History of headache
☐ History of migraines
☐ Vision problems
☐ Vision loss
☐ Ear problems
☐ Hearing loss

Women
☐ Pregnant, due:
☐ Gynecological conditions, what?
____

Substance Use
Cigarette use?
☐Never ☐Previously ☐Currently
How long? _____Quit date? _______
Alcohol use (drinks/week): ________

Lifestyle
Typical diet? ________________
Exercise/frequency: ____________
Sleep (hours/night): __________
Sleep position?☐Front☐Side☐Back

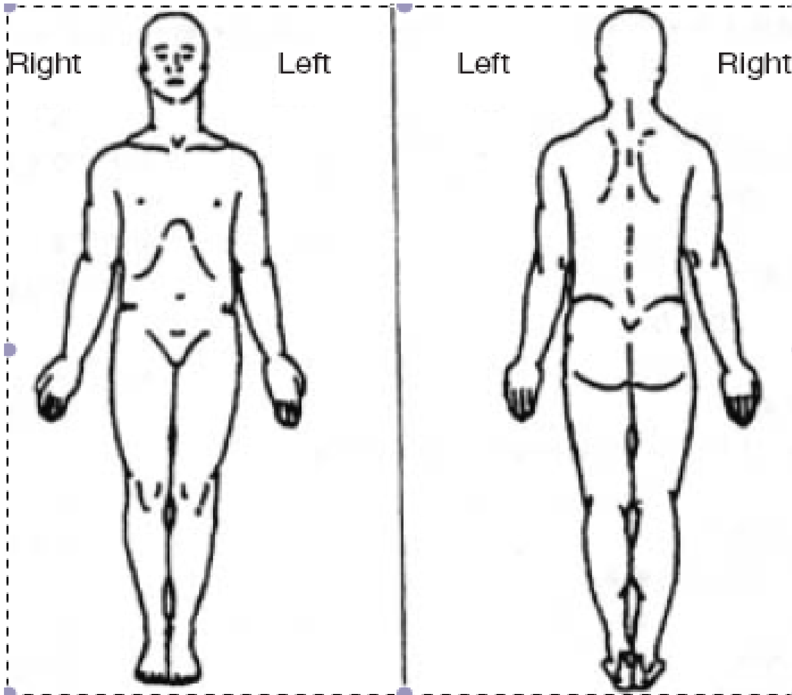
Current Medications: ______________________
____
Condition it treats: ______________________
____
Are you currently receiving treatment from another health care professional? If yes for what? __________
____
Surgery, date: ______________________
Nature: ______________________
Injury, date: ______________________
Nature: ______________________

Do you have any other medical conditions? ☐Yes ☐No
If yes, what? ______________________
Do you have any internal pins, wires, artificial joints or special equipment? ☐Yes ☐No
What? ______________________
Where? ______________________
How would you describe your overall health? __________
Primary Physician: ______________________
Contact details: ______________________

Current Symptoms

Please rate your pain intensity: 10 9 8 7 6 5 4 3 2 1 0 *(0 = no pain)*
When did it start? ____________________ How? ___________________________
Is it getting **better, worse** or **staying the same**? ______________________
Is it worse in the morning/ daytime/ evening? ____________________

Indicate with an **X** on the diagram below, the location of your pain.



Describe the character of your pain *(check all that apply):*

- ☐ Dull/achy
- ☐ Stiff/tight
- ☐ Sharp/stabbing
- ☐ Numbness/tingling
- ☐ Burning
- ☐ Catching
- ☐ Other: __________

What makes it worse?
____
____

What makes it better?
____
____

Notes (*Internal Use*): ____
____
____
____
____

____

CREDIT CARD AUTHORIZATION AND CONSENT FORM

I _______________________________________ hereby authorize Chiropractic and Massage in the Village to charge my credit card due to an outstanding payment, not having any Extended Health Insurance Coverage, Missed Appointment and/or Late Cancellations made in **less than 24 hours** of the appointment time. A team member from Chiropractic and Massage in the Village will contact me at the time of the transaction, to make me aware of any charges made.

PLEASE BE AWARE:

LATE CANCELLATIONS AND MISSED APPOINTMENTS WILL BE CHARGED FULL TREATMENT AMOUNTS

Type of Card: ☐ MasterCard ☐ Visa (NO Debit Visa Allowed)

Credit Card Number: _______________________________________

Expiration Date: _______________________________________

CVV: _______________________________________

Name of Cardholder: _______________________________________

Authorized Signature of Cardholder: _______________________________________

By signing this form, I acknowledge the charges described hereon and assume full responsibility for said charges and agree to honor and abide by the terms of payment. I acknowledge and accept Chiropractic and Massage in the Village Terms and Conditions.

Client Signature: _______________________________________

Date: _______________________________________