INTAKE FORM

Name_____ Birth Date_____ Email _____

Address _____ City_____ State_____ Zip_____

Phone #_____ Cell #_____Can we Text you reminders_____

Occupation _____ Hobbies/other activities _____

How did you hear about us? _____

Is there a specific reason you are seeking chiropractic care? _____

What type of care are you seeking? ☐ Relief ☐ Corrective ☐ Wellness

Are you currently under medical treatment? Y or N If yes, please specify. _____

_____

_____

Do you have any foreign metals, plastic, pacemaker, and/or stents in your body? Y or N If yes, please specify.

_____

Are you pregnant? Y or N If yes, how many months? _____

In case of emergency, whom may I contact?

Name:_____Phone:_____

I have filled out the intake forms to the best of my knowledge and understand that chiropractic treatments are not meant to replace a physician's treatment. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand that, as in the practice of medicine, there are some risks to chiropractic treatments, including but not limited to fractures, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to utilize his good judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from the doctor named below.

Patient Signature_____ Date _____

Doctor Signature _____ Date_____