



New Patient Intake Form

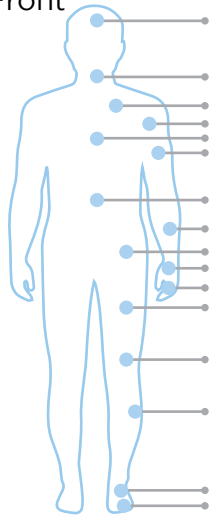
Fill out form digitally and [submit](mailto:vitalitychiropracticsarasota@gmail.com) form email back to vitalitychiropracticsarasota@gmail.com or print and bring in to our appointment.

Name: _____
Address: _____
City: _____
Phone: _____
Email: _____
SSN: _____

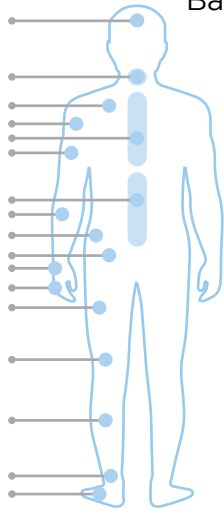
Today's Date: _____
Attorney Name: _____
(accident)
How did you hear about us?
Search Engine _____
Social Media _____
Referral _____
Other _____

CHIEF COMPLAINT

Front



Back



Please check off all areas of concern

Neck Pain ☐ Left Arm ☐ Right Arm ☐
Headaches ☐ Left Leg ☐ Right Leg ☐
Mid-Back Pain ☐ Left Shoulder ☐ Right Shoulder ☐
Lower Back Pain ☐ Other _____
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 | ☐ Fatigue |
| ☐ Arthritis | ☐ Fever |
| ☐ Bloody stool | ☐ Headaches |
| ☐ Bruise easily | ☐ Hypertension |
| ☐ Chest pain | ☐ Kidney Stone |
| ☐ Constipation | ☐ Liver Disease |
| ☐ Depression | ☐ Loss of Sleep |
| ☐ Diarrhea | ☐ Low Blood Pressure |
| ☐ Difficulty Breathing | ☐ Mental Illness |
| ☐ Dizziness | ☐ Nausea |
| ☐ Ear Ache | ☐ Tremors |
| ☐ Eye Problems | ☐ Weight Loss |

Family History

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

- | | |
|--|---|
| ☐ Arthritis | ☐ Hypertension |
| ☐ Autoimmune Disease | ☐ Neurological Disorder |
| ☐ Cancer | ☐ Osteoporosis |
| ☐ Diabetes | ☐ Respiratory Disease |
| ☐ Heart Disease | ☐ Stroke |
| ☐ High Cholesterol | ☐ 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 _____



Medical History

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

Medical History

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

List all the medications you are taking:

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)

<i>Supplement Name/Type</i>	<i>Frequency</i>	<i>Brand or Where Purchased</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.



Consent to Care

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



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 injuries 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