Patient Intake

Information contained within this form is considered strictly confidential. Your responses are important to help us better understand your health, goals of treatment, and ensure the delivery of the best possible care and support. This form must be fully completed before you can begin your care in our office.

Given Name :____Nickname: _____________________________
Gender identity/pronouns: _________________________ Date of birth: __________________ Age: ________
Address: ____
City: ____________________________ State: __________________Zip:_____________________________
Primary phone: _______________________________ Cell phone: ____________________________________
Email address: ____
Occupation: _________________________________ Employer: _____________________________________
Social security number: _________________________ Relationship status: ______________________________
Primary care provider: ____
Who lives with you (please list names, ages & relationship to you)? ___________________________________
____
____

May we leave you voicemails about your appointments? ____________________________________
Do you prefer to be contacted via phone, text or email? _____________________________________
How did you hear about our office? ____

Emergency Contact
Given Name (first, last): ____
Gender identity/pronouns: _________________________ Date of birth: __________________ Age: ________
Cell phone: ________________________________ Email address: ___________________________________
Relationship to you: ____

Insurance Information
Insurance company and plan name: ____
Name of policy holder: ____
Relationship to policy holder:____
Policy holder date of birth (mm/dd/yyyy): ____
ID number: ______________________________________ Group number: _____________________________

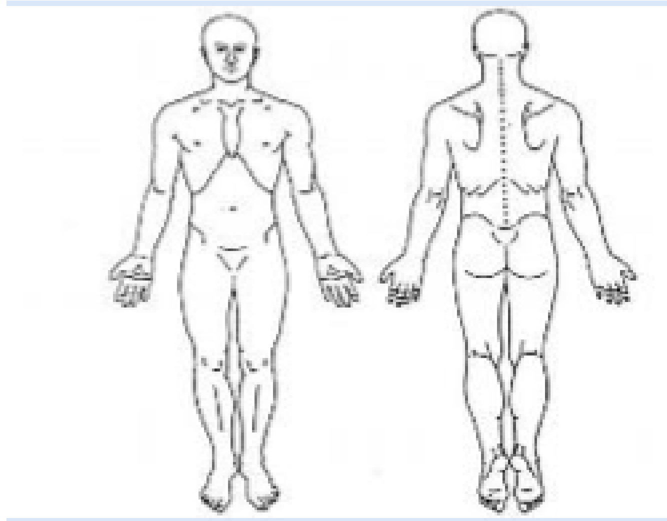
Please list any other providers you are working with:
Massage Therapist: __________________________ Therapist: ____
Acupuncturist: _______________________________ Fitness: ____
Physical Therapist: ____________________________Other:____
If you need a referral for any of the above providers please ask!

Describe the reason for your visit today:
____
____
____

Please list your specific goals for care in our office (*example: to exercise without pain, prevent illness, wellness care etc…):*
1.____
2.____
3.____

Musculoskeletal History

Please mark your symptoms on the diagram.



On a scale of 1(not intense) to 10 (you are unconscious with pain), how would you rate your symptoms:

1 2 3 4 5 6 7 8 9 10

When did your symptoms start? ____

How did your symptoms begin? ____

How often do you experience symptoms? Constantly Frequently Occasionally Intermittently

Describe your symptoms? Sharp Dull ache Numbing Burning Tingling Shooting

Other:____

Are your symptoms? Getting better Staying the same Getting worse

What aggravates your current symptoms? ____

What positions or activities relieve your current symptoms? ____

Have you experienced these symptoms in the past? ____

How do your symptoms interfere with your daily life? ____

Have you seen a chiropractor before? ___________________ If yes, Doctor's name: __________________________

How long since last chiropractic adjustment? ____

Have you seen any other health care provider for these symptoms? ______________________________________

Current Health History

What is your general state of health? ____

Do you exercise on a regular basis? ____

Do you have a specific diet? (vegetarian, gluten-free, vegan etc.)____

Allergies (environmental, food, medications etc.):____

____

Do you smoke:_________ How often?_____________ How many years have you been smoking?_______________

Do you drive alcoholic beverages? _______ drinks per day/week/month (circle)

Are you currently pregnant or breastfeeding? _______________________ If pregnant, how many weeks? _____

Current Medications (including over the counter):

Medication Name Purpose

1. ____ ____
2. ____ ____
3. ____ ____
4. ____ ____
5. ____ ____

Current Herbs/Supplements/Vitamins:

____
____
____

Please list any conditions you have been diagnosed with and the name of the medical provider who diagnosed it. State the year of diagnosis, and any treatment received or ongoing treatment:

____
____
____
____
____
____

Surgeries and/or hospitalizations (list dates, reasons, and any complications):

____
____
____

Do you have any implants/pins/screws? ____

Do you wear arch supports/heel lifts/orthotics/other supportive device? _________________________

Family History: list any significant family history for your immediate family (parents, siblings, kids)

____
____
____
____

Please add any other comments, thoughts, or questions you would like us to address.

____
____
____

Required Signatures
□ I authorize use of these intake forms on all of my insurance submissions.
□ I authorize release of information to my insurance companies.
□ I understand that I am responsible for my bill.
□ I authorize my doctor to receive payment for services rendered from my insurance company.
□ I understand that there may be charges that my insurance company may not cover.
□ I understand that copays are due at time of service and that Dr. Persoleo's Office will bill me for any co-insurance or balance owed.
□ I certify that the information on all of my intake forms is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_______________________________________ Date:_________________________________

Missed Appointment/Cancellation Policy
We understand that you may sometimes need to reschedule appointments. If you need to reschedule, please contact our office as soon as you know that you will not be able to keep the appointment. It is our office policy to **require 24 hours advance notice** for all appointment cancellations/reschedules to allow maximum availability for our patients. We welcome voicemails and emails left after hours. If you miss an appointment or cancel it with less than 24 hours notice, a missed appointment fee of $25.00 will be assessed to your account. This fee is not reimbursable by insurance and is the patients' responsibility. There is no fee for weather related cancellations.

Signature:____________________________ Date:_________________________

Informed Consent
To the patient: Please ask questions before you sign if there is anything that is unclear.
As with any healthcare procedure, there are certain complications that may arise during chiropractic adjustments and therapy. Complications may include: stiffness and soreness following the first few days of treatment, fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.
The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

I ____ understand the above information and consent to chiropractic care in this office under Drs. Michael and Abby Persoleo.
Signature: ____ Date: _________

For Office Use Only:

History:

Findings:

Recommended treatment plan:

Today's treatment:

Homecare:

Provider Signature: ____

Date: ____