The Disc Chiropractic (https://discinjurydoc.com)

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Profile Information — Step 1 of 4

You are completing the intake form: **Intake form (2022) Downloadable** for **

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

Only staff members can edit this information on an intake form.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Preferred Name (if different)

Pronouns

They/Them/Theirs

Prefix / Title

Mobile Phone – *Required*

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Home Phone

Country – *Required*

United States

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

State – *Required*

Postal / Zip – *Required*

Date of Birth – *Required*

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Occupation

Employer

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of referring professional

Referring professional phone (if known)

Referring professional email (if known)

How did you hear about us? *– Required*

How did you hear about us?

Please check that all required questions have been answered.

Continue

Insurance Information — Step 2 of 4

You are completing the following intake forms: Intake form (2022) Downloadable

New Policy

Listed below are the insurances that we are in-network with. We are accepting Medicare patients as a non-participating provider. Please share any insurance information you have available so we can prepare for your upcoming appointment.

Insurer

Select an option

Select the insurance company you would like to provide details for from the drop down menu below.
If you do not have any insurance details to provide select "None"

Questionnaires — Step 3 of 4

You are completing the following intake forms: Intake form (2022) Downloadable

Intake form (2022) Downloadable

Patient Information

Primary Language Spoken:

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:

Number of Children:

Children's Names & Ages

Why this form is important

In our office we focus on your ability to be healthy. The goal is address the issues that brought you to the office and offer you the opportunity to improve your health potential. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Research shows that most health challenges that occur later in life have their origins during the developmental years, some starting at birth.

- [ ] Check here if you have no specific symptoms or complaints, and are here for wellness services. Skip to "Your Health Goals".

Current Health Conditions

Reason for visit:

When did it start?

Have you received care for this problem? If yes, please explain:

How did the condition(s) first begin?

What makes the problem better?

What makes it worse?

Is the condition:

- [ ] Getting Worse
- [ ] Improving
- [ ] No Change

Is the condition:

- [ ] Intermittent (on and off)
- [ ] Constant
- [ ] Unsure

Describe the pain:

- [ ] Aching
- [ ] Sharp
- [ ] Numb
- [ ] Dull
- [ ] Burning
- [ ] Tingling
- [ ] Deep
- [ ] Throbbing
- [ ] Other

Rate your pain level

0 1 2 3 4 5 6 7 8 9 10

When your condition is at its worst, does it interfere with:

- [ ] Your ability to work?
- [ ] Your ability to enjoy family/social time?
- [ ] Your ability to enjoy sports or hobbies?

If it isn't corrected, do you think this will get worse over the next 5 years?

- [ ] Yes
- [ ] No

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem:

0 1 2 3 4 5 6 7 8 9 10

For Women Only:

Are you pregnant?:
Due Date:
Are you currently nursing?

Your Health Goals

Describe your health goals:

Chiropractic History

What would you like to gain from chiropractic care?

- [ ] Resolve existing condition(s)
- [ ] Overall wellness
- [ ] Both

Have you ever visited a chiropractor before?

- [ ] Yes
- [ ] No

For what reason did you visit a chiropractor?

Health History

Indicate if you or any immediate family members have any of the following:

- [ ] Rheumatoid Arthritis
- [ ] Diabetes
- [ ] Lupus
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Stroke
- [ ] Cancer

For each of the conditions listed below, please check the box if you have had the condition in the past or currently:

- [ ] Headaches
- [ ] Broken bones
- [ ] Drug/Alcohol dependence
- [ ] Neck pain
- [ ] Pacemaker
- [ ] Allergies
- [ ] Upper back pain
- [ ] Dizziness
- [ ] Depression/Anxiety
- [ ] Midback pain
- [ ] Chest pain
- [ ] Dermatitis/Eczema/Rash
- [ ] Low back pain
- [ ] Thyroid problems
- [ ] Concussion
- [ ] Joint swelling
- [ ] Asthma
- [ ] Birth Control Pills
- [ ] Arthritis
- [ ] Sinus problems
- [ ] Menstrual Irregularity/Cramping
- [ ] General fatigue
- [ ] Diarrhea/Constipation

☐ Memory problems ☐ Tobacco Use

Physical Stress/Traumas: Physical Injury History

Have you every had any significant falls, surgeries, accidents or injuries as an adult?

☐ Yes ☐ No

If yes, please explain:

Have you ever been hospitalized?

☐ Yes ☐ No

If yes, why?

Notable childhood injuries?

Youth or college sports?

Describe any car accidents you've been in:

Exercise Frequency:

☐ 1-2x/week ☐ 3-5x/week ☐ Daily ☐ Never

What types of exercise do you perform?

How do you normally sleep?

☐ Back ☐ Side ☐ Stomach

Do you wake up:

☐ Refreshed ☐ Stiff & Tired

Do you commute to work?

☐ Yes ☐ No

How many minutes per day do you commute to work?

How many hours per day do you typically spend sitting?

Allergies:

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking, and why:

Chiropractic Care

The purpose of our chiropractic care is to support and empower you in achieving your optimum health and to educate you so that you may understand your health and chiropractic.

Back Continue

Consents — Step 4 of 4

You are completing the following intake forms: Intake form (2022) Downloadable

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [x] I would like email notifications of new, cancelled, and rescheduled appointments
- [ ] Email 2 days before appointment
- [ ] Text Message (SMS) 24 hours before appointment
- [ ] Text Message (SMS) 2 hours before appointment

Intake form (2022) Downloadable — Consents

Accuracy of Information

- [ ] I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] I agree – *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we ask 12 hours notice for any cancellations or changes to your appointment as a courtesy.

- [ ] I am aware of the Cancellation Policy. – *Required*

Signature

(•) **Draw** ( ) **Type**

Please check that all required questions have been answered.

Submit Intake Form