BLAINE CHIROPRACTIC & MASSAGE

Chiropractic Intake Form

Patient Information

First and Last **Name**: _____
Preferred Name: _____
Date of Birth: _____

Mobile Phone: _____ Home Phone: _____
Email:_____

Address _____ City _____State_____ Zip_____

Patient **Occupation**: _____ Employer: _____

Guardian if Minor: _____ Marital Status: _____
Emergency Contact Name/Phone/Relationship: _____

Spouse's Name and DOB if **Insurance Policyholder**: _____
Insurance Provider: _____
Policy Number: _____Group Number: _____
SEX must match insurance: ☐ Male ☐ Female GENDER ☐ Male ☐ Female ☐ Non-binary

Doctor or Referring Professional: _____
Phone: _____ Clinic or Facility Name: _____
How did you hear about us? ☐ Friend ☐ Physician/Specialist ☐ Web ☐ Insurer's List

Current Health Conditions

Reason for visit _____.
When did it start? _____ Have you received care for this problem?
If yes, please explain: _____
What makes the problem better or worse?
_____

Is the condition: ☐ Getting Worse ☐ Improving ☐ No Change
Is the condition: ☐ Intermittent (on and off) ☐ Constant ☐ Unsure

Type of Pain: ☐ Aching ☐ Dull ☐ Deep ☐ Sharp ☐ Burning ☐ Throbbing ☐ Numb
☐ Tingling ☐ Other: _____Rate your pain level (0 = none, 10 = unbearable):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe your Health Goals: _____

What would you like to gain from chiropractic care?
☐ Symptomatic Relief ☐ Corrective Care ☐ Both

Have you ever visited a chiropractor before? ☐ Yes ☐ No If yes, what was the reason and did it help? _____

Physical Injury History

Notable childhood injuries: _____

Youth or college sports: _____

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

Were you ever hospitalized? ☐ Yes ☐ No If yes, why?
_____

Describe any car accidents you've been in:
_____

Health History

Pregnancy/Childbirth History (including number of children):
_____

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

Circle or check if you currently have or have had the following:

☐ Headaches	☐ Neck pain	☐ Upper back pain	☐ Back pain
☐ Low back pain	☐ Shoulder pain	☐ Arm pain	☐ Wrist pain
☐ Hand pain	☐ Upper leg pain	☐ Hip pain	☐ Knee pain
☐ Ankle/Foot pain	☐ Jaw pain	☐ Joint swelling	☐ Arthritis
☐ Muscular incoordination	☐ General fatigue	☐ Vision problems	☐ Ringing in the Ears
☐ Memory problems	☐ Broken bones	☐ Pacemaker	☐ Dizziness
☐ Heart Attack	☐ Chest pain	☐ Stroke	☐ Angina
☐ Kidney Stones	☐ Kidney disorders	☐ Bladder issues	☐ Prostate problems
☐ Abdominal pain	☐ Weight change	☐ Appetite loss	☐ Cold hands/feet
☐ Liver disease	☐ Thyroid issues	☐ Asthma	☐ Sinus problems
☐ Alcohol/Drug use	☐ Allergies	☐ Anxiety/Depression	☐ Hormonal replacement
☐ Birth Control	☐ Pregnancy	☐ Epilepsy	☐ Skin rashes
☐ Concussion	☐ Diabetes (again)	☐ Excessive thirst	☐ Frequent urination
☐ Ulcers	☐ Hepatitis	☐ Tumors	☐ Gallbladder issues
☐ Anemia	☐ Osteoporosis	☐ Other	

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Indicate if you or any IMMEDIATE family members have had the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Lupus

☐ Stroke ☐ Cancer ☐ Thyroid Disorders ☐ Epilepsy ☐ Osteoporosis

Lifestyle & Daily Habits

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 If yes, how many minutes/day? _____
How many hours per day do you typically spend sitting? _____

Please Rate your **Consumption** of the following (1=Never 4=Frequent)

Alcohol: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Water: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Sugar: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Dairy: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Gluten: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Caffeine: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Processed Foods: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Artificial Sweeteners: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Soda: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Cigarettes/Tobacco: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Recreational Drugs: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Fast Food: ☐ 1 ☐ 2 ☐ 3 ☐ 4

List Any **Allergies**: _____

Dietary habits, exclusions and supplements:

_____

Medications: Use end of form if more room is needed

_____

Current **Stress** Levels: ☐ Low ☐ Medium ☐ High

Sports and hobbies, current and past, reasons for stopping:

_____

Expectations of Care: How many visits with Dr. Andruscavage do you anticipate? _____

Is there anything else your provider should know?:

_____

Accuracy of Information

I certify that the above **medical information** is correct to my knowledge.

Patient Signature: _____ Date: _____

Guardian Signature if Minor_____ Date: _____

Consent & Office Policies

Initial each section and sign below.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information. I also authorize communication with my family or referring doctor when necessary. My information is confidential and will only be disclosed with my permission.

Initials: _____

Cancellation Policy

Appointments require 24 hours' notice for cancellation or changes. Missed visits or late cancellations will incur a $40 fee.

Initials: _____

Payment at Time of Service

I understand that payment (copay, deductible, or private pay) is due the day of service, based on my insurance plan and Good Faith Estimate (GFE). I may be billed for any remaining balance after insurance processes. Outstanding charges due after 90 days will be charged to the card on file and statement of charges sent to email on file.

Initials: _____

Communication Consents

Email and Texts

☐ I would like to receive email and text notifications for appointments and updates.

Authorization to Leave Detailed Messages

I authorize the staff to leave voicemail messages including protected health information (PHI) such as treatment plans and billing details. This authorization remains in effect until revoked in writing.

☐ I agree to authorize detailed voicemail messages.

Signature: _____ Date: _____

Guardian Signature if Minor_____ Date: _____

Guardian Name Printed and Relationship: _____