Patient Intake Form & Office Policies

Please complete this form in full. Your information helps us provide the best possible care. Thank you for choosing Motion Chiropractic!

Patient Information

Name:	
Date:	
Address	
ZIP	
Date of Birth	
Phone	

Reason for Visit

What brings you in today?

How long have you had this issue?

Have you seen another provider about this? □ Yes □ No
If yes, what treatments were performed?

Is this the result of an accident or injury? □ Yes □ No
If yes, please describe:

Does the pain radiate or travel? □ Yes □ No

Describe the intensity, and frequency of your symptoms:

What makes it better or worse?

How does this impact your daily routine?

Have you ever been to a chiropractor? □ Yes □ No

If yes, when was your last treatment?

Review of Systems

Check any current or recent symptoms:

□ **Fever, chills, sweats**
□ **Nausea or vomiting**
□ **Chest pain or pressure**
□ **Shortness of breath**
□ **Skin issues (acne, rash, psoriasis)**

□ **Changes in balance or speech**
□ **Changes in memory or cognition**
□ **Vision changes (blurred or loss)**
□ **Heartburn or indigestion**
□ **Frequent stools**
□ **Constipation**
□ **Diarrhea**
□ **Headaches or migraines**
□ **Painful joints**
□ **Muscle weakness**
□ **Tingling or numbness**
□ **Neuropathy (nerve pain, burning, or loss of sensation)**

Other symptoms you'd like to mention:

Medical History

Check any that apply:

□ **High Blood Pressure**
□ **Type 2 Diabetes or Pre-diabetes**
□ **Acid Reflux/GERD**
□ **Thyroid Disorders**
□ **Depression**
□ **Anxiety**
□ **Chronic Pain (nerve pain, arthritis)**
□ **Asthma/COPD**
□ **Infections**

□ **Insulin Resistance**

Other diagnoses:

Surgical History

Check any past surgeries:
□ Cataract Surgery
□ Cesarean Section
□ Joint Replacement (Hip or Knee)
□ Gallbladder Removal
□ Hernia Repair
□ Appendectomy
□ Heart Bypass Surgery
□ Hysterectomy
□ Spinal Surgery (Fusion, Disc Repair/Removal)

Other surgeries:

Do you have any implanted devices or artificial joints (such as pacemakers, joint replacements, spinal stimulators, etc.)? □ Yes □ No
If yes, please list: _____

Lifestyle

Do you take any vitamins or minerals? □ Yes □ No

Do you engage in strength or resistance training? □ Yes □ No

Do you walk, jog, ride bike, or swim at least 3 times a week? □ Yes □ No

How would you describe your diet?

Have you ever tried eliminating inflammatory foods? □ Yes □ No

Red meat?

a] Causes heart disease and cancer

b] Should be eaten in small quantities.

c] Is a superfood that promotes health and wellbeing.

Do you smoke tobacco? □ Yes □ No
Do you drink alcohol? □ Yes □ No

How many hours of sleep do you get per night?
□ Less than 5 □ 5-7 □ 7-9 □ 9+

Stress level (0 = None, 10 = Severe): _____

How much water do you drink daily?

Goals for Care

□ **Pain relief**
□ **Improved range of motion and strength**
□ **Improved balance and coordination**
□ **Better sleep**
□ **More energy**
□ **Improved quality of life**
□ **Lose some weight without dieting**

Other goals:

HIPAA Privacy Statement

At Motion Chiropractic, we are committed to protecting the privacy and security of your health information. The Health Insurance Portability and Accountability Act (HIPAA) requires that we safeguard your protected health information (PHI) and provide you with this notice of your rights and our responsibilities.

Your Health Information Rights

- **Access and copies of health records**
- **Request corrections**
- **Restrict certain uses**
- **Receive disclosures list**
- **Request confidential communication**

How We May Use and Share Your Information

- **Treatment coordination**
- **Payment processing**
- **Healthcare operations**

We will not share your information without authorization, except as required by law.

Our Commitment to You. We maintain your privacy as required by law and will notify you of significant changes.

Patient Name: _____

Signature: _____

Date: _____