

Vida Family Wellness

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NEW PATIENT INTAKE FORM

Complete at home, print, and bring to your first visit.

Self-pay practice · Superbill provided upon request

1. PERSONAL INFORMATION

First Name		Last Name		Preferred Name	
Date of Birth	Age	Gender	Pronouns	Occupation	
Phone		Email		Preferred contact	
Street Address			City	State	ZIP
How did you hear about us?			Referring doctor / person		

2. EMERGENCY CONTACT

Emergency Contact Name	Relationship	Phone
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3. MEDICAL HISTORY — Check all that apply

☐ High blood pressure	☐ Heart disease	☐ Diabetes	☐ Arthritis
☐ Osteoporosis	☐ Fibromyalgia	☐ Cancer	☐ Stroke
☐ Asthma	☐ Thyroid disorder	☐ Anxiety	☐ Depression
☐ Headaches / Migraines	☐ Herniated / Bulging disc	☐ Scoliosis	☐ Sciatica
☐ Carpal tunnel	☐ Auto accident injury	☐ Work-related injury	☐ Sports injury
☐ Pregnancy	☐ Pacemaker		
<u>Other conditions / surgeries / hospitalizations:</u>			
Current Medications (name & dosage)		Allergies	

4. CURRENT COMPLAINT — Reason for Your Visit

Primary reason for your visit:

When did this start?	Pain today — circle: 0 1 2 3 4 5 6 7 8 9 10	Pattern (circle): Constant / Intermittent
Pain location(s):		
☐ Head	☐ Neck	☐ Upper back
☐ Lower back	☐ Shoulder (L)	☐ Shoulder (R)
☐ Hip (R)	☐ Arm / Hand (L)	☐ Arm / Hand (R)
☐ Leg / Knee (R)	☐ Jaw / TMJ	☐ Chest
☐ Mid back		☐ Hip (L)
		☐ Leg / Knee (L)
		☐ Abdomen
What makes it BETTER?		What makes it WORSE?
Previous treatment for this complaint:		
☐ Physical therapy	☐ Massage	☐ Medication
☐ Chiropractic	☐ Acupuncture	☐ Surgery
☐ None		☐ None
Prior chiropractic care?		
☐ Yes ☐ No		
Prior acupuncture?		
☐ Yes ☐ No		
Currently pregnant?		
☐ Yes — Weeks: _____ ☐ No ☐ Postpartum — Weeks since delivery: _____		

5. ACUPUNCTURE & TCM (for acupuncture patients)

Energy level	Sleep quality
☐ High ☐ Moderate ☐ Low ☐ Very low	☐ Excellent ☐ Good ☐ Fair ☐ Poor

Digestion
☐ Normal ☐ Bloating ☐ Reflux ☐ Constipation

Stress level
☐ Low ☐ Moderate ☐ High ☐ Very high

Current symptoms:

☐ Dizziness	☐ Tinnitus
☐ Hot flashes	☐ Cold hands/feet
☐ Frequent urination	☐ Dry skin
☐ Muscle cramps	☐ Heart palpitations

Temperature
☐ Runs cold ☐ Runs warm ☐ Balanced ☐ Varies

Emotional state
☐ Positive ☐ Anxious ☐ Sad/down ☐ Irritable

☐ Blurred vision	☐ Night sweats
☐ Numbness/tingling	☐ Shortness of breath
☐ Poor appetite	☐ Sugar cravings
☐ Menstrual irregularities	☐ Water retention

Health goals: _____

6. INFORMED CONSENT & SIGNATURE

I hereby request and consent to chiropractic adjustments, acupuncture treatments, and related procedures as administered by Vida Family Wellness. I understand chiropractic care involves spinal adjustments and acupuncture involves insertion of thin needles. Potential risks include temporary soreness and, in rare cases, more serious complications. Results are not guaranteed and I may discontinue care at any time. I acknowledge that Vida Family Wellness is a self-pay practice; a superbill will be provided upon request for submission to my insurance for potential out-of-network reimbursement. I confirm the information provided is accurate and I consent to examination and treatment.

Patient Signature

Date

Printed Name

For patients under 18 — Parent/Guardian Signature
