

# Roswell Family Chiropractic

**PLEASE PRINT NEATLY!**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Marital Status: \_\_\_\_\_

# of Children: \_\_\_\_\_

Names with Ages of People Living With You:



How did you hear about us / Who referred you?  
\_\_\_\_\_  
\_\_\_\_\_

What is your reason for seeking the services of chiropractic?  
\_\_\_\_\_  
\_\_\_\_\_

Circle and explain if you are currently taking any of the following:

Prescription drugs

Non-prescription drugs

Herbs

Homeopathic Remedies

Supplements

Are you following a special diet? If yes, explain \_\_\_\_\_

Do you smoke? If yes, how much \_\_\_\_\_

Do you drink alcohol? If yes, how much \_\_\_\_\_

Do you drink coffee or tea? If yes, how much \_\_\_\_\_

Hours of sleep per night: \_\_\_\_\_

Describe your quality of sleep: (Excellent / Good / Average / Sporadic / Poor) \_\_\_\_\_

List your history of significant falls, accidents, and major injuries (give dates):  
\_\_\_\_\_  
\_\_\_\_\_

List your history of hospitalizations or surgeries (give dates):  
\_\_\_\_\_  
\_\_\_\_\_

List your chiropractic history (give dates):  
\_\_\_\_\_  
\_\_\_\_\_

Circle all modalities you are currently doing:

Chiropractic

Counseling

Exercise

Massage

Meditation

Physical Therapy

Yoga

Have you previously addressed the situation for which you are seeking my services? If YES, explain type of care and give dates:  
\_\_\_\_\_  
\_\_\_\_\_

How would you grade your current overall: Physical state?  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to achieve from receiving chiropractic care?  
\_\_\_\_\_  
\_\_\_\_\_

Please include other information you feel will be helpful regarding your situation:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any chiropractic concerns you would like me to address *before* we begin? If YES, explain:  
\_\_\_\_\_  
\_\_\_\_\_

(continue on the other side)

## **UNDERSTANDING THE OBJECTIVES**

The purpose of this side of the intake form is to clearly state the objectives of chiropractic in this office. Initial each statement in the space provided to the left to indicate your complete understanding of the following:

- \_\_\_\_\_ Chiropractic is the science which concerns itself with the relationship between structure, primarily the spine, and function, primarily the nervous system, of the human body.
- \_\_\_\_\_ Michael A. Scimeca, D. C. does not name or treat symptoms, conditions, or ailments of any kind.
- \_\_\_\_\_ Dr. Scimeca simply locates and corrects vertebral subluxations (misalignments of the spine).
- \_\_\_\_\_ He does NOT discourage you from seeking out medical professionals who name and treat conditions.
- \_\_\_\_\_ To get a timely diagnosis, you must take yourself to a professional who practices the art of diagnosis.
- \_\_\_\_\_ Dr. Michael A. Scimeca does NOT practices the art of diagnosis.
- \_\_\_\_\_ Any sickness, disease, or condition concern you may have should be brought to the attention of licensed medical healthcare professional who practices the art and science of diagnosis and treatment.
- \_\_\_\_\_ Additional information about this office is available at [www.RoswellFamilyChiropractic.com](http://www.RoswellFamilyChiropractic.com).
- \_\_\_\_\_ Suggestions regarding wellness-related practices are NOT a replacement for professional counseling or any form of medical treatment.
- \_\_\_\_\_ Questions regarding office procedures or policies should be brought to our attention immediately.

**Initial the following statements to approve the usage of chiropractic as practiced by Dr. Scimeca:**

\_\_\_\_\_ I, the undersigned, approve the use of chiropractic for the location and correction of subluxations.

**For the parent or guardian of a minor child:**

\_\_\_\_\_ I, the undersigned, state that I am the legal parent or guardian of the minor child listed on this form.

\_\_\_\_\_ I fully understand the objectives of this office and how they apply to my minor child.

\_\_\_\_\_ I give consent for my minor child listed on this form to receive care in this office.

*My signature below indicates my complete understanding to all the above. I also understand that payment is due in full at the time services are rendered – unless prior arrangements have been made.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU FOR THIS OPPORTUNITY TO SERVE YOU**