ROLLING HILLS CHIROPRACTIC + WELLNESS

New Patient Intake Form

PATIENT INFORMATION

Legal Name: _____	Preferred Name: _____
Date of Birth: _____	Email: _____
Address: _____	City/State/ ZIP: _____
Mobile Phone: _____ Emergency Contact: _____	Home Phone: _____ Relationship / Phone: _____
□ Male □ Female □ Other / self-describe □ Prefer not to answer	Occupation / Employer: _____
Payment/Coverage Type:	

Self-Pay □ Insurance □ Auto Injury/Claim □ Workers Compensation □

REASON FOR VISIT

Wellness Care □ New Injury □ Chronic Injury/Condition (>3 months) □

Primary reason for today's visit: _____

When did your symptoms begin?

_____

□ Sudden onset □ Gradual onset □ Work-related □ Auto accident □ Other: _____

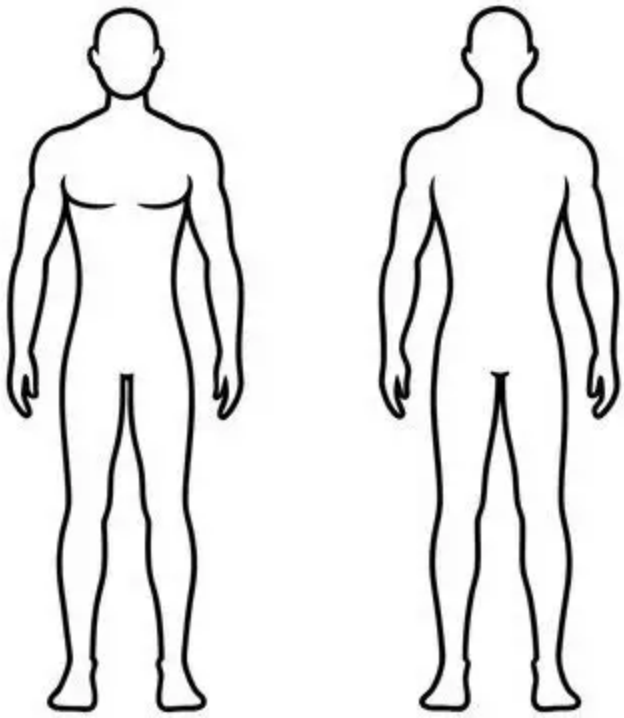
Describe symptoms: _____

Pain / symptom level today (0–10): 0 1 2 3 4 5 6 7 8 9 10

What makes it better? _____ What makes it worse? _____

Have you had this condition before? □ No □ Yes —
explain:_____

What is your main goal for care? _____



Please circle or mark areas of pain, discomfort, numbness, tingling, or other symptoms.

□ Aching □ Sharp □ Burning □ Numbness

□ Tingling □ Stiffness □ Other: _____

MEDICAL HISTORY

□ No significant medical history □ Pregnant / possibly pregnant □ High blood pressure

□ Heart Disease □ Diabetes □ Cancer □ Osteoporosis / osteopenia □ Arthritis □ Seizures

□ Stroke / TIA □ Blood clot / bleeding disorder □ Recent infection / fever □ Recent fracture/ trauma □ Surgery □ Numbness / tingling □ Weakness □ Dizziness / fainting □ Bowel or bladder changes □ Other

Please explain any items checked: _____

Current medications / supplements: _____

Medication / other allergies: _____

Past surgeries / hospitalizations: _____

Family history relevant to your care: _____

LIFESTYLE

□ Never tobacco □ Former tobacco □ Current tobacco / nicotine

□ No alcohol □ Occasional alcohol □ Regular alcohol

Exercise / physical activity: _____

Anything else you want your chiropractor to know: _____

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Health History, Privacy & Consent

HIPAA NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGMENT

I acknowledge that I have been offered or provided access to Rolling Hills Chiropractic + Wellness's Notice of Privacy Practices. The Notice explains how my protected health information may be used and disclosed for treatment, payment, and health care operations and describes my privacy rights. I understand that I may request a paper copy of the Notice and that the practice may revise the Notice as permitted by law.

□ I received / was offered the Notice of Privacy Practices □ I decline a paper copy at this time

Communication preferences: I authorize the practice to contact me regarding appointments, treatment, billing, and other health care matters using the methods I provide, subject to applicable law.

□ Phone call □ Voicemail □ Text message □ Email

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for charges for services provided to me, except to the extent payment is required from another party under an applicable contract or law. Insurance billing is a courtesy and does not guarantee payment. I am responsible for applicable deductibles, copayments, coinsurance, non-covered services, and balances permitted by my health plan and law. I agree to provide accurate insurance information and notify the practice of changes. I authorize release of information reasonably necessary to obtain payment and, when applicable, authorize payment of insurance benefits directly to Rolling Hills Chiropractic + Wellness. I understand that estimates of insurance benefits are not guarantees of coverage or payment.

Signature: _____ Date: _____

Patient/Legal Representative Printed Name: _____

CONSENT TO CHIROPRACTIC EXAMINATION & TREATMENT

I voluntarily consent to evaluation and treatment by the licensed chiropractor(s) at Rolling Hills Chiropractic + Wellness. I understand that care may include history and examination, orthopedic/neurologic testing, chiropractic adjustments/manipulation, soft-tissue techniques, therapeutic exercise or rehabilitation, and other procedures within the chiropractor's scope of practice that are discussed with me. I understand the nature and purpose of proposed care, reasonable alternatives (including declining or postponing care), and that no specific result or cure can be guaranteed.

I understand that chiropractic care is generally considered low risk, but side effects or complications can occur. These may include temporary soreness, stiffness, bruising, increased symptoms, dizziness, headache, and, rarely, fracture, disc injury, nerve injury, or other serious complications. Spinal manipulation involving the neck has been reported in association with cervical artery injury and stroke; the relationship and frequency are uncertain, and such events are considered rare. I understand that I should tell the chiropractor about changes in my health, medications, pregnancy status, recent trauma, or new neurologic or other concerning symptoms.

My rights: I may ask questions at any time, request additional information, refuse any procedure, or withdraw consent to future treatment. My signature confirms that I have had the opportunity to ask questions and that my questions have been answered to my satisfaction.

□ I consent to chiropractic examination and treatment as described above

SIGNATURES

Patient / Legal Representative Printed Name: _____	Date: _____
Signature: _____	