



Intake Form

Date: _____

Name: _____

Email address: _____

Phone number: _____

Address: _____

Date of birth: _____

Sex: (Circle one) Male/Female/ X

Occupation: _____

Guardian : _____

Emergency Contact: _____

How did you hear about us? _____

Insurance Company info: _____

Health History Questionnaire

Network Spinal Intake Form

Please complete this general health history. It will provide your practitioner with important information that will enable them to better understand your history and long term needs, as well as any health related quality of life issues you may be experiencing.

Do you have any current health or life concerns? If so, please describe them:

Please rate the level this health concern affects these areas of your functioning/quality of life.

(circle one)

Work

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Walking

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Love life

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Recreation

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Sitting

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Concern about the symptom

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Rest/sleep

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Exercise

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Social Life

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Eating

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Concern over health

0-it does not affect me 1-slightly 2-moderately 3-Quite a bit

Is there any activity during which you totally or almost totally forget about this concern?

Why do you think this has happened or continues to happen?

If this condition or symptom were to go away tomorrow, what would be different about your life?

Are you doing anything different because of this concern?

What is the pain, circumstance, or experience asking you to change? What is the message in what's happening?

If required, are you willing to make changes in your health choices, lifestyle, perspectives, or other areas to resolve this concern? (If not, what prevents this?)

Please list any surgeries you have had and the results:

List any drugs: prescriptions, over the counter, shots/vaccines you are currently taken or have taken in the past 3 months: _____

Please List any herbs/supplements that you are taking or have taken in the past 3 months:

Which best describes your current experience of yourself and your situation (select up to 3)

_____ It seems like nothing works. It seems like it will never end.

_____ I want to get rid of this painful situation. I feel like I need to find the cause.

_____ I feel stuck or blocked and am being held back.

_____ I am willing to peel back my illusions, stories, rules, and beliefs and be with whatever is there to find what's real.

_____ I will do whatever it takes, as I am so ready for resolution. These patterns once served me but no longer do.

_____ I accept what has happened and will happen. I am very blessed.

_____ I look for the gift, even in the pain. I realize that we all connect and everything is purposely organized.

Have you received any type of chiropractic care in the past?

_____ YES _____ NO

Have you received Network Spinal care in the past?

_____ YES _____ NO

Have you had any experience with the following treatments or modalities?

_____ Massage/bodywork

_____ Music/dance/sound/light therapy

_____ Ayurvedic Medicine

_____ Nutritional Counseling

- ____ Breathwork
- ____ Somato Respiratory Integration
- ____ Psychotherapy/Emotional Therapy
- ____ Acupuncture
- ____ Yoga/Tai Chi/QiGong
- ____ Other: _____

When Stressed, how do you “center” or regroup? _____

Please rate the following stressors in order of increasing intensity:

Overall Physical Stress/Trauma

0-No awareness of stress 1-slightly stressful 2-moderately stressful 3-Extremely stressful

Overall emotional/mental stress

0-No awareness of stress 1-slightly stressful 2-moderately stressful 3-Extremely stressful

Overall Chemical Stress

0-No awareness of stress 1-slightly stressful 2-moderately stressful 3-Extremely stressful

Are there any particular factors about your life experience, family, work, recreation, past injuries, genetics, dietary programs, exercise, outlook, etc. that you feel impairs your opportunity for full glowing health? _____

Are there any particular factors about your life experience, family, work, recreation, past injuries, genetics, dietary programs, exercise, outlook, etc. that you feel gives you an edge or adds to your health? _____

When communicating to you about your spine, nervous system, health, and wellness please check your preference:

- ____ Mostly speak with me about the clinical findings.
- ____ Mostly show me in written form about the findings.
- ____ Mostly let me feel a sense of the clinical work.

Is there anything else which may help us better understand you, your history, or your professional needs which have not been addressed on this form? _____

What would motivate you to communicate to others about the care you receive in this office, and to encourage others to seek care? _____

Network Spinal is not band aid care. To be considered for care, you are required to be an active participant. Before submitting this form, please understand that consistency in your visits is how you will achieve the results you desire.

____ I am ready to be an active participant in my wellbeing

____ I only want to see the doctor for a quick fix and realize that Network Spinal may not be for me.

I have answered this questionnaire honestly and to the best of my ability.

Signature:

Consents

Communication

Appointment Notifications and Reminders

Email:

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

I would like email notifications of new, cancelled, and rescheduled appointments

Email 2 days before appointment

Text Message (SMS) (you can check both)

Text message 24 hours before appointment

Text message 2 hours before appointment

News and Special Promotions

Yes, I would like to receive the monthly newsletter and class schedule right to my email!

Health History Questionnaire- Consents

Accuracy of Information:

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

Privacy and Sharing of Information:

I authorize A Garden for Wellness and it's associates and health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my medical doctor and referring doctor as needed and deemed necessary for my beneficial treatment. I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I agree

Cancellation Policy:

Your appointment is reserved just for you. A late cancellation or missed appointment can cause another patient to be unable to be seen by the doctor. As such, we do require 24 hour notice for cancellations or changes to your appointment. Patients who provide less than 24 hour notice, or miss their appointment will be charged a cancellation fee to the card on file. Extenuating circumstances warrant our discretion in charging the cancellation fee.

____ I am aware of the cancellation policy

Media Consent:

I understand that A Garden for Wellness may occasionally capture photos or videos during Network Spinal sessions for educational and promotional use, including social media, websites, and other professional platforms.

____ I agree to allow photo/video content of my sessions to be used. I understand that my identity will remain confidential unless I provide explicit permission to be identified.

____ I do *not* agree to any photo or video content

Signature:
