



New Member Intake Form

PERSONAL INFORMATION

First Name. _____ MI. _____ Last Name. _____ DOB. _____
Address. _____
City. _____ State. _____ Zip Code. _____
Phone. _____ Email. _____
Occupation. _____ Marital Status. _____
How did you hear about us? _____

EMERGENCY CONTACT

Name. _____ Number. _____ Relationship. _____

CURRENT CONCERNS

Primary Complaint: _____

Onset Date: _____

Has it changed since onset? ☐ Same ☐ Better ☐ Worse

Pain description: ☐ Aching ☐ Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Burning ☐ Other: _____

Pain intensity (0 = none, 10 = worst): _____

How it affects daily activities: _____

Secondary Complaint: _____

Onset Date: _____

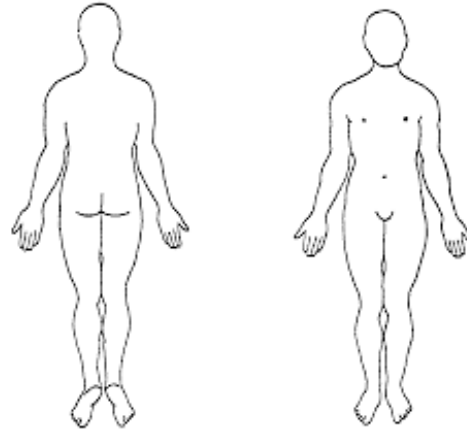
Has it changed since onset? ☐ Same ☐ Better ☐ Worse

Pain description: ☐ Aching ☐ Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Burning ☐ Other: _____

Pain intensity (0 = none, 10 = worst): _____

How it affects daily activities: _____

Mark corresponding concern areas:



CURRENT STATUS

Do you have a Pacemaker: ☐ Yes ☐ No

Are you Pregnant (Female only): ☐ Yes ☐ No

Do you have a current active cancer diagnosis: ☐ Yes ☐ No

In the last 48hrs, have you taken any NSAIDs? (Advil/Ibuprofen, Meloxicam, Voltaren/Diclofenac, Naproxen Celebrex, etc.): ☐ Yes ☐ No

In the last 3mo, have you had epidurals, cortisone, or other steroid injections: ☐ Yes ☐ No

In the last 3mo, have you taken any oral steroids(Prednisone, Methylprednisolone, Dexamethasone, Triamcinolone, Betamethasone): ☐ Yes ☐ No

MEDICAL HISTORY

- Current Medications/Supplements:

- Past Surgeries / Hospitalizations:

- Major Accidents or Injuries:

- Serious Illnesses / Diagnoses:

How have you taken care of your health in the past?

- | | |
|--|--|
| ☐ Medications | ☐ Holistic Care |
| ☐ Emergency Room | ☐ Vitamins |
| ☐ Routine Medical | ☐ Chiropractic |
| ☐ Exercise | ☐ Other (Please Specify)_____ |
| ☐ Nutrition/Diet | _____ |

How did the previous method(s) work out for you?

- | | |
|--|---|
| ☐ Bad Results | ☐ Did Not Get Worse |
| ☐ Some Results | ☐ Did Not Work Very Long |
| ☐ Great Results | ☐ Still Trying |
| ☐ Nothing Changed | ☐ Confused |

How have others been affected by your health condition?

- | | |
|---|---|
| ☐ No One Is Affected | ☐ They Tell Me To Do Something |
| ☐ Haven't Noticed Any Problems | ☐ People Avoid Me |

What are you afraid this might be (or beginning) to affect (or will affect)?

- | | |
|---|-----------------------------------|
| ☐ Job | ☐ Sleep |
| ☐ Kids | ☐ Time |
| ☐ Future Ability | ☐ Finances |
| ☐ Marriage | ☐ Freedom |
| ☐ Self-Esteem | |

Are there health conditions you are afraid this might turn into?

- | | |
|---|--|
| ☐ Family Health Problems | ☐ Fibromyalgia |
| ☐ Heart Disease | ☐ Depression |
| ☐ Cancer | ☐ Chronic Fatigue |
| ☐ Diabetes | ☐ Need Surgery |
| ☐ Arthritis | |

How has your health condition affected your job, relationships, finances, family, or other activities?

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.).

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

What would be different/better without this problem?

What do you desire most to get from working with us?

What would that mean to you?

Please check any that apply to you:

Sub-Clinical Symptoms:

- ☐ Headaches
☐ Migraines

Hormone Imbalance:

- ☐ PMS
☐ Emotional imbalance

Gastrointestinal Issues:

- ☐ Abdominal bloating
☐ Cramps or painful gas
☐ Irritable Bowel Syndrome
☐ Ulcerative Colitis
☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions:

- ☐ Chronic sinusitis
☐ Asthma
☐ Allergies

Circle the number that most closely fits, then add up your results.

Constipation and/or Diarrhea	o	1	2	3
Abdominal Pain or Bloating	o	1	2	3
Joint pain, swelling, or arthritis	o	1	2	3
Food allergies, sensitivities, or intolerances	o	1	2	3
Sinus or Nasal Congestion	o	1	2	3
Chronic or frequent Inflammations	o	1	2	3
Eczema, Skin rashes, or hives	o	1	2	3

Joint Conditions:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions:

- ☐ Diabetes Mellitus
☐ Lupus
☐ Rheumatoid Arthritis
☐ Fibromyalgia
☐ Chronic Fatigue

Thyroid Conditions:

- ☐ Hashimoto's
☐ Hypothyroidism
☐ Hyperthyroidism

Developmental and Social Concerns:

- ☐ Autism
☐ ADD/ADHD

Skin Conditions:

- ☐ Eczema
☐ Skin rashes
☐ Hives

Asthma, Hayfever, or airborne allergies	o	1	2	3
Confusion, poor memory, mood swings	o	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	o	1	2	3
History of Antibiotic Use	o	1	2	3
Alcohol Consumption makes you feel sick	o	1	2	3
Nausesa	o	1	2	3
Weight Issues	o	1	2	3
Eczema, Skin rashes, or hives	o	1	2	3

Total: _____

Office Policies

- If insurance does not cover a service, I am responsible for payment.
- Commonly non-covered services (e.g., ART, AK, MTA, Heat, Stim, Muscle Work, Extremities, Cranials, Visceral Manipulation) incur a **\$20 fee** unless verification is confirmed.
- Acupuncture, Softwave, MLS Laser, and Wellness Chiropractic (including packages/subscriptions) are self-pay/HSA/FSA only.
- Please arrive on time. Cancellations without **24-hour notice** may result in a **\$25 fee** after the first warning.

☐ **I have read and agree to the office policies.**

Informed Consent for Care

I understand that treatments (Manual Adjustments, Myofascial Therapy, Class IV Laser, Softwave, Acupuncture) are generally safe but may have risks, including soreness, bruising, fatigue, or temporary pain increase. Alternatives have been discussed, and I may refuse treatment at any time.

☐ **I understand and consent to the recommended care.**

HIPAA Notice of Privacy Practices

I acknowledge that **Treasure Coast Spine & Sport** maintains and protects my personal health information (PHI) in accordance with federal law. My health information may be used or disclosed for treatment, payment, or healthcare operations.

I understand that:

- My records may be shared as needed for coordination of care and insurance processing.
- Other uses or disclosures will only occur with my written authorization.
- I have the right to review, request a copy, or place restrictions on my health information, and to file a complaint if I believe my privacy rights have been violated.
- A **full copy of the Notice of Privacy Practices** is available in the office upon request.

☐ **I have read and understand the HIPAA Notice above.**

Signature: _____ **Date:** ____/____/____