Profile Information — Step 1 of 5

You are completing the intake form: **Chiropractic Intake Form**

Please take a moment to fill out our intake form before your visit.

All information is kept completely confidential.

First Name – *Required*

Last Name – *Required*

Preferred Name (if different)

Pronouns

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Mobile Phone – *Required*

A mobile phone is required if you would like to receive SMS appointment reminders.

Street Address – *Required*

City – *Required*

State – *Required*

Postal/Zip – *Required*

Date of Birth – *Required*

Gender – *Required*

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Occupation

Emergency Contact – *Require*

Emergency Contact Phone – *Required*

Emergency Contact Relationship – *Required*

How did you hear about us?

Insurance Information — Step 2 of 5

Your insurance policy

Insurer

Subscriber #

Group #

Questionnaires — Step 3 of 5

Chiropractic Intake Form

Chiropractic Patient Intake

In order to provide you the best possible holistic care, please complete this form. All information is strictly CONFIDENTIAL.

Is your current complaint directly related to an automobile accident or workers compensation case?

☐ No

☐ Yes - Please include Insurance claim number, company name, contact person and phone number.

Auto Accident Claim Information

Please describe your primary or major complaint (please provide a brief description of your primary area of complaint)

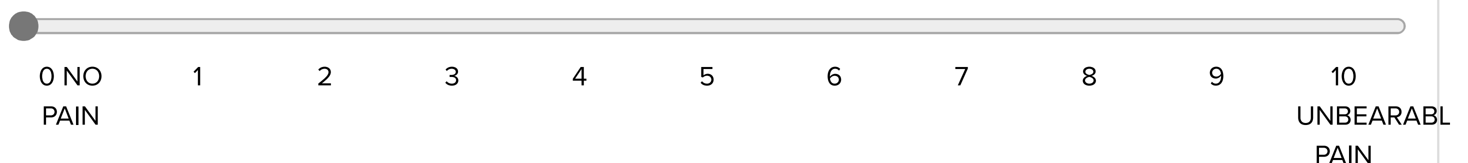
What is your complaint? (Why are you seeking care?)

Have you had this same condition before?

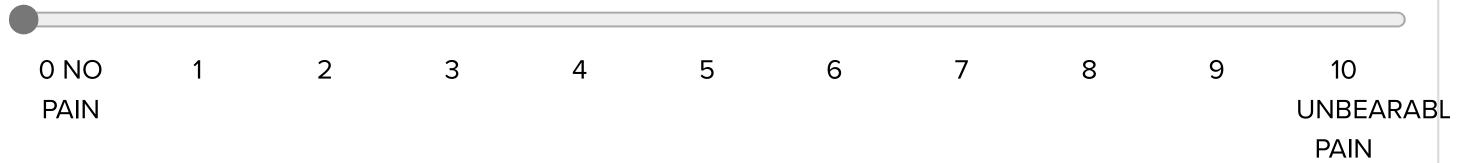
☐ No ☐ Yes - When?

When was the last episode? Please describe....

On the scale below, please indicate your pain or discomfort you have RIGHT NOW.



On the scale below, please indicate your WORST pain in the past week.



Secondary or other areas of complaint. (IF APPLICABLE)

Have you received any of these therapies for this complaint?

- [ ] Surgery
- [ ] Acupuncture
- [ ] Massage Therapy
- [ ] Chiropractic Care
- [ ] Physiotherapy

Health History Questionnaire (please check all current or previous conditions as they may apply)

General Symptoms

- [ ] Allergies
- [ ] History of Headaches
- [ ] History of Migraines
- [ ] Generalized Pain
- [ ] Night Pain
- [ ] Loss of consciousness
- [ ] Blackouts
- [ ] Fever
- [ ] Excess Sweating
- [ ] Nervousness

Other Symptoms

- [ ] Numbness or tingling
- [ ] Dizziness
- [ ] Blurred Vision
- [ ] Fainting
- [ ] Problem Speaking
- [ ] Nausea

Eyes / Ears / Nose / Throat Symptoms

- [ ] Ringing / Buzzing in ears
- [ ] Eye Pain
- [ ] Failing Vision
- [ ] Vision Problems
- [ ] Hearing Loss
- [ ] Other Hearing problems not otherwise listed

Respiratory Symptoms

- [ ] Asthma
- [ ] Chronic Cough
- [ ] Difficulty Breathing
- [ ] Shortness of breath
- [ ] Bronchitis
- [ ] Emphysema

Cardiovascular Symptoms

- [ ] Previous Incident of Stroke
- [ ] Cerebral Vascular Aneurism
- [ ] Previous Heart Attacks
- [ ] Chronic Congestive Heart Failure
- [ ] Other Heart / Blood Disease not discussed
- [ ] Hardening of Arteries
- [ ] Bleeding Disorder
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Angina
- [ ] Phlebitis / Varicose veins
- [ ] Pacemaker or similar device

Gastrointestinal Symptoms

- [ ] Diabetes
- [ ] Ulcer
- [ ] Irregular / Absent bowel movement
- [ ] Indigestion

Genitourinary Symptoms

- [ ] Trouble Urinating
- [ ] Kidney Infection
- [ ] Prostate Trouble

Genitourinary Symptoms (Female only)

- [ ] Hot Flashes
- [ ] Irregular / Absent Cycle
- [ ] Cramping / Backache

Have you ever had any fractures ? (If Yes, please provide details and dates)

- [ ] NO
- [ ] YES (Describe the location of fracture and when it occured)

Describe the fracture

Have you ever been diagnosed with Cancer ? (If Yes, please provide details and dates)

- [ ] NO
- [ ] YES (Describe where and the date diagnosed)

Cancer Diagnosis and Date

Please list your current Medication, Herbs, Supplements.

What are your main interests and hobbies?

Please describe your physical activity level, activities you partake in and how frequently you participate.

Please add any additional information that you feel is pertinent

Family Medical History (Please check all applicable conditions)

- [ ] Headaches or Migraines
- [ ] High or Low blood pressure
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Fainting or Dizziness
- [ ] Stroke
- [ ] Circulatory Problems
- [ ] Cancer
- [ ] Neurological disorders

- [ ] Kidney disease
- [ ] Chron's Disease
- [ ] Pelvic Inflammatory disease
- [ ] Asthma
- [ ] Respiratory disorders
- [ ] Rheumatoid arthritis
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Fibromyalgia
- [ ] Epilepsy
- [ ] Skin Conditions Multiple Sclerosis

Are you a patient in the UNC System? *– Required*

If YES, Dr. Drew will be able to access medical records if needed

Consents — Step 4 of 5

You are completing the following intake forms: Chiropractic Intake Form

Communication

Appointment Notifications and Reminders

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

Email

- [ ] Email 2 days before appointment

Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

- [ ] Text Message (SMS) 2 hours before appointment
- [ ] Text Message (SMS) 24 hours before appointment
- [ ] Text Message (SMS) 45 minutes before appointment

Phone Call

- [ ] Phone Call 24 hours before appointment

News and Special Promotions

- [ ] We don't send out many emails. If you choose to opt-out, we're obligated to honor your request, meaning you won't receive any important clinic updates.

Chiropractic Intake Form — Consents

Accuracy of Information

- [ ] I certify that the above medical information is correct to my knowledge. – *Required*

Informed Consent to Treat

Welcome to chiropractic care. Chiropractic focuses on the relationship between the brain, nervous system, spine, and body function. Disruptions in this relationship may lead to vertebral subluxation complex (VSC) with physical and chemical components affecting health. Chiropractic care includes exams, diagnostic tests, specialized tools, and manual or instrument-based adjustments to reduce or stabilize VSC. Chiropractors are regulated professionals required to disclose care risks.

Chiropractic care avoids drugs and surgery and doesn't diagnose internal medical conditions. It's provided by licensed chiropractors. While risks exist (e.g., musculoskeletal issues, neurological deficits), they're rare (approximately 1 in 400,000 to 1 in 1,000,000 treatments). You'll be informed if you're at risk. Feel free to ask questions. By signing, you agree to the recommended care, understanding there are no guarantees of cure or specific results.

- [ ] I agree – *Required*

HIPAA PRIVACY NOTICE

This notice explains how Heartwood Holistic Health (HHH) protects the privacy of your Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA). Please read this notice carefully and contact our Privacy Officer at (HeartwoodHolistic@gmail.com) if you have any questions.

Privacy Practices: HHH collects, uses, and discloses your PHI for purposes such as treatment, payment, and healthcare operations. We are committed to safeguarding your PHI.

Uses and Disclosures: We may use and disclose your PHI for authorized purposes, including treatment, payment, healthcare operations, and as required by law. Your consent will be obtained for any other uses or disclosures.

Individual Rights: You have the right to access, request amendments, request restrictions, and file complaints regarding your PHI. Contact our Privacy Officer for assistance with these rights.

Notice of Breach: In the event of a breach of your PHI, we will notify you as required by HIPAA regulations.

Contact Information: If you have any questions, concerns, or need to exercise your rights under HIPAA, please contact our Privacy Officer at HeartwoodHolitic@gmail.com.

Language Accessibility: This notice is available in multiple languages upon request. Translation services are available for individuals with limited English proficiency.

Revision and Updates: HHH may revise and update this notice as necessary. You can obtain the most current version at our office or on our website.

- [ ] I acknowledge that I have received and read the HIPAA Privacy Notice. – *Required*

Self-Pay Policy & Insurances Accepted

Heartwood Holistic Health accepts medical insurance. Please inform us to check if we are in-network. We can provide a visit statement (super bill) for self-claim filing upon request.

☐ I understand and agree that I will pay Heartwood Holistic Health directly for all services rendered. – *Required*

Cancellation Policy

Your appointment is reserved exclusively for you. To avoid a $42 cancellation fee, please give us at least 24 hours' notice for any changes or cancellations. This helps us accommodate other patients and minimize disruptions to our therapists' schedules.

☐ I understand – *Required*

Freed Medical Transcribe Software

To give you the best care and attention, I'll be using a service that transcribes our conversation. If you don't want me to be using it, just let me know and I'll turn it off.

◯ **I Agree**

◯ **I Disagree**

ACKNOLWEDGEMENT:
I agree that this consent form may be handwritten or electronically signed and that my electronic signature appearing on this consent form is the same as handwritten signatures for the purpose of validity, enforceability, and admissibility. I understand that I can opt-out of signing this document electronically by contacting Heartwood Holistic Health. I understand that I may receive an electronic copy of this consent form by requesting it from Heartwood Holistic Health and providing my email address and Heartwood Holistic Health will email the form to me. If I am unable to receive the form via email, I can notify Heartwood Holistic Health and other arrangements can be made. I have read this description of services and understand and consent to the information presented above. I understand that I can discuss any questions with Heartwood Holistic Health. I understand there are potential risks and benefits associated with chiropractic services. I have the right to make decisions about the chiropractic services I receive, to refuse chiropractic services, and revoke this consent any time. I understand I have an opportunity to discuss questions regarding services with my provider at Heartwood Holistic Health. I understand that the provider may determine that it is not appropriate for me to receive chiropractic services at any time. In this case, I understand that I will be notified of this decision and will be provided resources for accessing more appropriate health services.

Patient Signature	**Date**