

Dorr CHIROPRACTIC

Dorr Chiropractic New Member Intake Form

First Name: _____

Phone Number: _____

Last Name: _____

Email: _____

Address: _____

Occupation: _____

City: _____

Sex (choose one): **Male** ☐ **Female** ☐

State: _____

Marital Status: _____

Zip: _____

Date of Birth: _____

How did you find out about this office? _____

Pricing Options

(please check the box for option that works best for you)

Pay as You Go

☐ **Adults: \$45 per visit**

-First Visit is \$60- includes consult fee

-Services Performed: Chiropractic Adjustment and
10 min in Rove Pro Massage Chair
(price may vary if only one of the
above services is rendered)

☐ **Kids (under 18): \$15 per visit**

Services Performed: Chiropractic Adjustment
(under 18 not permitted in massage chairs)

PrePaid Wellness Plans

☐ **6 Visit Wellness Plan**

\$240

SAVE \$5 per visit!

-consult fee waived!
-expires in 6 months

☐ **12 Visit Wellness Plan**

\$420

SAVE \$10 per visit!

-our best value!
-consult fee waived!
-expires in 12 months

*Each visit includes chiropractic adjustment
and 10 minutes in RovePro massage chair.

**Plans are nonrefundable and
nontransferable to other people

Consent to Initiate Care

At Dorr Chiropractic, our goal is to provide the highest quality chiropractic care focused on wellness, prevention, and optimal function through spinal and extremity joint adjustments and the use of Human Touch® WholeBody® Rove PRO massage chairs.

Please review the information below to understand our office procedures, policies, and the benefits/risks of chiropractic care. Feel free to ask questions at any time, in person, by phone, or by text.

Office Policies

- **Non-Insurance Office:** Dorr Chiropractic is not in-network with any insurance company or third-party payer. You may submit your receipts to your insurance or health program for possible reimbursement, but payment is due at the time of service. Dorr Chiropractic is not responsible for non-payment or denial by any insurance company.
- **Paperwork & Records:** Dorr Chiropractic does not complete or submit insurance paperwork, claim forms, or reports for any insurance, legal, or personal injury purposes. Patients may request a copy of their records for personal use.
- **Work-Related or Accident Injuries:** Care at this office is not intended for treatment of automobile, work-related, or personal injury claims. Such cases must be managed by your medical provider.
- **Payments:** All care is provided on a walk-in, first-come, first-served basis. Payment is due at the time of service. Balances may not be carried or billed.
- **Right to Refuse Care:** Dorr Chiropractic and Dr. Mike Dumond reserve the right to decline or discontinue care for any reason, including if it is determined that chiropractic care is not appropriate or beneficial for the individual.

Nature of Care and Consent

By signing below, I acknowledge that chiropractic care at Dorr Chiropractic may include:

- Manual chiropractic adjustments of the spine and/or extremities for the purpose of improving joint motion, alignment, and function.
- Use of the Human Touch® WholeBody® Rove PRO massage chair, which provides automated mechanical massage for relaxation and wellness.

I understand that these services are provided for wellness and preventive purposes—to support spinal health, mobility, and nervous system function. I also understand that chiropractic care, like any healthcare service, carries inherent risks. These may include, but are not limited to, temporary soreness, sprain/strain, muscle spasms, or, in rare cases, fracture, dislocation, disc injury, or stroke following an adjustment.

By signing below, I consent to receive chiropractic care and related services at Dorr Chiropractic. I understand that I am under no obligation to continue care and may discontinue at any time.

Print Name: _____

Signature: _____

Date: _____

Parental Consent to Evaluate and Treat a Minor

By signing below, I, _____, being the parent or legal guardian of _____, authorize Dorr Chiropractic and Dr. Mike Dumond to evaluate and provide chiropractic care and massage chair use for my child as deemed appropriate for wellness and preventive purposes.

Parent/Guardian Signature: _____

Date: _____

Questions? We welcome you to ask Dr. Dumond or staff anytime about your care or our office procedures.

SOME QUESTIONS TO GET US STARTED

List the ISSUES that bring you into the office:

For each issue, WHEN did it start?

For each issue, HOW did it start?

For each issue what PROVOKES IT/MAKES IT WORSE?

For each issue, what RELIEVES IT/MAKES IT BETTER?

For each issue, DESCRIBE THE SYMPTOMS (ex: achy, dull, shooting):

For each issue, do you have TINGLING/NUMBNESS/SHOOTING anywhere?

For each issue, RATE SEVERITY 1-10 (10 being the worst):

For each issue, list the DOCTORS/THERAPISTS YOU'VE SEEN and WHAT THEY DID (ex: medication, therapy):

When was the last time you had IMAGES OF YOUR SPINE taken (Xray, MRI, CT scan)?

Have you ever BEEN TO A CHIROPRACTOR or BEEN ADJUSTED before?

List any SURGERIES you've had and note the year each occurred:

List any SIGNIFICANT INJURIES you've had and note the year each occurred:

List any SIGNIFICANT DISEASES or health problems you've had:
