

# *Dorr* CHIROPRACTIC

## Dorr Chiropractic New Member Intake Form

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

City: \_\_\_\_\_

Sex (choose one): ☐ Male ☐ Female

State: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

How did you find out about this office? \_\_\_\_\_

## Member Fee Schedule

(Please check your preference)

### Pay Per Adjustment

(Pay per visit)

☐ **Adult - \$30**  
(18 and older)

☐ **Kid - FREE**

(up to 2 kids under 18 FREE with one or more parents who are getting adjusted at the same time- each additional child is \$22. A child getting adjusted without a parent is also \$22)

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**OR**

### Pay Ahead Pricing

(You will be provided with a punch card to track adjustments)

☐ **4 Adjustments- \$100 (\$25/adjustment)**

☐ **8 adjustments- \$176 (\$22/adjustment)**

## Consent to Initiate Care

At Dorr Chiropractic there is one simple goal, to provide the highest quality chiropractic adjustments at the lowest possible fees. In order to accomplish this goal, I have instilled specific office procedures. Please read over these procedures along with the benefits/risks of chiropractic adjustments below to understand how the office functions and to decide if you wish to participate. If you have any questions, please direct them to me in person or via phone call/text anytime.

- Dorr chiropractic is not in-network with any insurance companies or third-party payers
- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. Dorr Chiropractic takes no responsibility for non-payment by insurance companies for services rendered at this office
- Dorr chiropractic will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any member's case. However, members may have a copy of their records
- By signing below, I acknowledge that Dorr Chiropractic and Dr. Mike Dumond do not provide care for work related injuries, automobile accident injuries or personal injuries. I also acknowledge that I must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained in these events. Dorr Chiropractic will also not bill, submit claims nor prepare or submit reports for any automobile, work-related or personal injury
- No balances can be kept by members at any time and adjustments are paid for on day of service
- Adjustments at Dorr Chiropractic are on a walk-in, first come first serve basis. No appointments are needed or honored
- Dorr Chiropractic and Dr. Mike Dumond reserve the right to deny services to anyone for any reason, or if the doctor feels that the member's health is not being best served
- By signing below, you understand that chiropractic adjustments at Dorr Chiropractic are for the purposes of wellness and spinal hygiene in order to detect and improve subluxations within the musculoskeletal system. Adjustments are performed to help the body heal more efficiently
- By signing below, you also agree to the understanding that any intervention, including chiropractic adjustments, comes with inherent risks and/or benefits. While rare it is possible to sustain injuries including but not limited to muscular soreness, sprain/strains, fractures, dislocations, disc injuries and stroke following a chiropractic adjustment

I have read the Consent to Initiate Care statements above, understand the procedures of the office as well as the benefits and risks of chiropractic adjustments and wish to initiate care at this office. I also understand that I am under no obligation to receive or continue care if I so choose.

Print your name: \_\_\_\_\_ Date: \_\_\_\_\_

Sign your name: \_\_\_\_\_

## PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

By signing above, I \_\_\_\_\_, being the parent/legal guardian of \_\_\_\_\_ hereby grant permission for my child to receive chiropractic care.

\*\*\*\*\*PLEASE SEE NEXT PAGE FOR ADDITIONAL QUESTIONS\*\*\*\*\*

# *Dorr* CHIROPRACTIC

## SOME QUESTIONS TO GET US STARTED

List the issues that bring you into the office:

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For each issue, WHEN did it start?

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For each issue, HOW did it start?

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For each issue what PROVOKES IT/MAKES IT WORSE?

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

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

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For each issue, do you have TINGLING/NUMBNESS/SHOOTING anywhere? Particularly down one or more arms/legs?

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

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For each issue, note the TIME OF DAY IT'S WORST? If constant, write constant:

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For each issue, list the ACTIVITIES/HOBBIES YOU HAVE BEEN UNABLE TO DO because of your problem:

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

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

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Have you ever been to a chiropractor or been adjusted before?

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\*\*\*\*\*PLEASE SEE NEXT PAGE FOR ADDITIONAL QUESTIONS\*\*\*\*\*

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

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

List any SIGNIFICANT DISEASE in your immediate family (ex: heart disease, diabetes, autoimmune disease, cancer):

List any SIGNIFICANT HEALTH PROBLEMS you currently have (ex: heart, lung, digestive, skin, autoimmune, etc.):

What activity or activities do you partake in most often on a daily basis (ex: sit at desk at work, stand, bend/lift/twist)?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you feel you have a purpose in life?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel you generally have healthy relationships in your life?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you get up to 6-9 hours of uninterrupted sleep per night?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you meditate or pray or do breathwork on a daily basis?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you get outside regularly?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would you say you currently have a strategy for health/wellness/injury prevention?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your diet consist of mainly real whole foods (fruit, veggies, beans, rice, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you exercise and move your body on a daily basis?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**What are you hoping to achieve by coming to Dorr Chiropractic?**

- ☐ **Symptom relief**- relief of pain through chiropractic adjustments
- ☐ **Wellness**- routine adjustments for improved wellness/healing
- ☐ **Relief with transition to wellness**
- ☐ **Unsure**- I'd like you to help me select what is appropriate

**Office use only: SFMA screen**

CS: Flex DN DP FP

Ext: DN DP FP

Rot L: DN DP FP

Rot R: DN DP FP

MRE L: DN DP FP

MRE R: DN DP FP

LRF L: DN DP FP

LRF R: DN DP FP

MSF: DN DP FP

MSE: DN DP FP

MSR L: DN DP FP

MSR R: DN DP FP