



GETZIK FAMILY
CHIROPRACTIC
PROFESSIONALS IN CHIROPRACTIC

CHIROPRACTIC

patient intake forms

Please fill out this form completely and accurately to help us provide the best possible care.

PATIENT INFORMATION:

Fullname:	Date of Birth:
Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address:	
City:	Post Code:
Contact No: Occupation:	Email:
Emergency Contact Name:	Employer:
Relationship:	
	Phone:

PRIMARY REASON FOR VISIT:

WHEN DID THE PROBLEM START?

- Sudden onset Gradual onset

TYPE OF PAIN:

- Sharp Dull/Achy Burning Tingling/Numbness Other: _____

PAIN SEVERITY (0 = NO PAIN, 10 = WORST PAIN):

- 0 1 2 3 4 5 6 7 8 9 10



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CHIROPRACTOR

patient intake forms

MEDICAL HISTORY: (CHECK ALL THAT APPLY)

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes (Type 1 / Type 2) |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cancer (type): _____ | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other: _____ |

SURGERIES / HOSPITALIZATIONS (WITH YEAR):

CURRENT MEDICATIONS / SUPPLEMENTS:

ALLERGIES:

LIFESTYLE FACTORS:

- Physical Activity Level: None Light Moderate High
- Average Hours Sitting Per Day: _____
- Do you smoke? Yes No
- Alcohol use: None Occasionally Regularly

Patient Signature over
printed name

Date Signed



CHIROPRACTIC TREATMENT

Consent Form

Please read carefully and sign below.

I, _____, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by **Dr. Stefan Getzik, DC and Getzik Family Chiropractic, LLC** including but not limited to, spinal manipulations, soft tissue techniques, rehabilitative exercises, and lifestyle counseling, as deemed necessary by my chiropractor.

I understand that:

1. Chiropractic care is generally safe and effective but, as with any healthcare procedure, there are risks. These may include, but are not limited to, muscle soreness, stiffness, temporary increase in symptoms, and in rare cases, injury to bones, joints, or nerves.
2. Results are not guaranteed, and outcomes vary depending on the individual's condition, adherence to treatment recommendations, and other health factors.
3. I have the right to ask questions about my treatment at any time and may withdraw consent at any time.
4. If I have a condition that requires attention from another healthcare provider, my chiropractor will advise me accordingly.

Acknowledgment of Risks:

I have read, or had read to me, the above consent. I have had an opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the nature of the proposed treatment and have been informed of the risks involved.

Patient Signature over printed
name

Date Signed

Chiropractor Signature over printed
name

Date Signed



HIPAA PRIVACY POLICY

Acknowledgement

PRIVACY PRACTICES ACKNOWLEDGEMENT

Protecting your personal health information is important to us. This notice describes how your medical information may be used and disclosed, and how you can access this information.

OUR RESPONSIBILITIES:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices.
- Follow the terms of the notice currently in effect.

YOUR RIGHTS:

- Request a copy of your medical records.
- Request corrections to your records if you believe they are inaccurate.
- Request restrictions on certain uses or disclosures of your information.
- Receive a list of certain disclosures we have made of your health information.

USE AND DISCLOSURE OF HEALTH INFORMATION:

- We may use or share your information: For your treatment (e.g., sharing with another healthcare provider). For payment purposes (e.g., submitting claims to insurance). For healthcare operations (e.g., quality assessment, training). When required by law (e.g., public health reporting). We will not use or disclose your health information for marketing purposes without your written authorization.
-

ACKNOWLEDGMENT OF RECEIPT:

I acknowledge that I have received a copy of the HIPAA Privacy Practices from **Getzik Family Chiropractic, LLC**.

Patient Signature over
printed name

Date Signed



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CHIROPRACTIC HEALTH

history questionnaire

Please complete this form to help us better understand your overall health and any conditions that may affect your care.

GENERAL HEALTH INFORMATION:

Height: _____

Weight: _____

Do you have a primary care physician? Yes No

Date of last physical exam: _____

CURRENT SYMPTOMS: (CHECK ALL THAT APPLY)

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Arm Pain/Numbness |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Leg Pain/Numbness |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Jaw Pain (TMJ) |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Other: _____ |

PAIN DETAILS:

- When did the pain start? _____ How did it
- start? Injury Gradual Unknown Other: _____ Pain
- severity (0-10): _____ Pain frequency: Constant Comes & goes
- What makes it worse? _____ What makes it
- better? _____
- _____

PAST MEDICAL HISTORY:

- Previous accidents or injuries: _____
- Past illnesses: _____
- Surgeries & dates: _____



CHIROPRACTIC HEALTH

history questionnaire

FAMILY MEDICAL HISTORY: (CHECK IF ANY FAMILY MEMBERS HAVE)

- Arthritis
- Cancer
- Diabetes
- Heart Disease
- Osteoporosis
- Other: _____

LIFESTYLE & HABITS:

- Exercise: None 1-2x/week 3-4x/week Daily
- Sleep: _____ hours/night
- Stress Level: Low Moderate High
- Diet: Healthy Average Poor

Patient Signature over
printed name

Date Signed



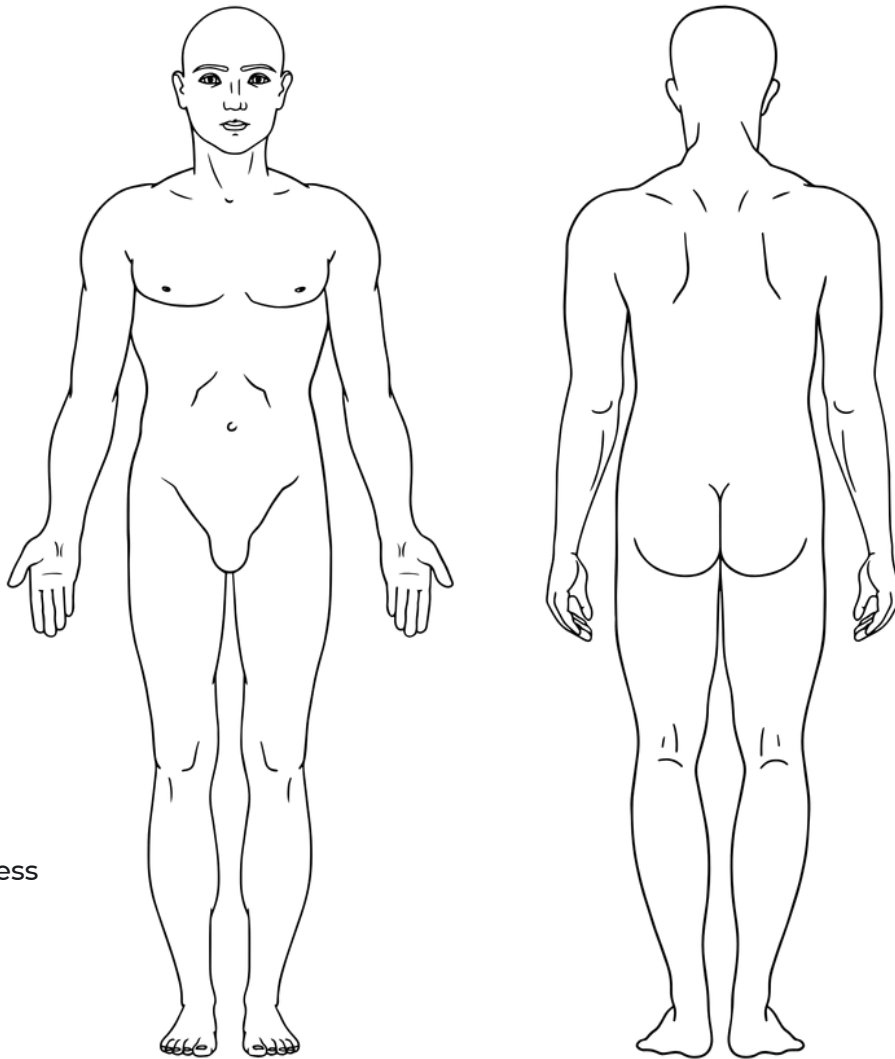
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BODY PAIN

diagram

Please mark the areas on the figures below where you feel pain, numbness, or discomfort. Use the symbols below to indicate the type of sensation.

PAIN SYMBOLS KEY:



- X = Sharp Pain
- O = Dull/Achy
- ~ = Burning
- = = Tingling/Numbness
- ★ = Stiffness



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BODY PAIN

diagram

PAIN NOTES:

PAIN LEVEL (0-10): _____

FREQUENCY:

- Constant
- Intermittent
- Only during activity
- Only at rest

Patient Signature over
printed name

Date Signed



GETZIK FAMILY
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FINANCIAL AGREEMENT/ *payment policy*

Please review and sign to confirm understanding of our billing procedures and payment responsibilities.

Patient Name: _____

Date: _____

PAYMENT TERMS:

- Payment is due at the time of service unless other arrangements are made in advance.
- We accept: Cash Credit/Debit Check Insurance Other: _____

INSURANCE:

- If you have insurance, we will bill your provider as a courtesy.
- Any co-pays, deductibles, or non-covered services are your responsibility.
- Verification of benefits is not a guarantee of payment by your insurance.

MISSED APPOINTMENT POLICY:

- Missed appointments or late cancellations (less than 24 hours) may be subject to a fee of \$_____.
- Repeated missed appointments may result in loss of scheduling privileges.

ADDITIONAL CHARGES:

- Returned checks will incur a \$_____ fee.
- Interest of ___% per month will be applied to unpaid balances over 30 days.

AGREEMENT:

I have read and understand the payment policy of **Getzik Family Chiropractic, LLC**. I agree to be financially responsible for all services rendered to me, regardless of my insurance coverage.

 Patient Signature over printed name

 Date Signed

 Clinic Representative Signature over printed name

 Date Signed



ASSIGNMENT OF BENEFITS

Patient Name:	Date of Birth:
Insurance Company:	
Policy Number:	Group Number:

I hereby authorize **Getzik Family Chiropractic, LLC** to release all medical information necessary to process my insurance claims and secure payment for services provided.

I authorize payment of insurance benefits directly to **Getzik Family Chiropractic, LLC** for services rendered to me. I understand that I am financially responsible for any charges not covered by my insurance, including co-pays, deductibles, and non-covered services.

This authorization will remain in effect until I provide written notice of revocation.

Patient Signature over printed
name

Date Signed

Clinic Representative Signature over
printed name

Date Signed



LIABILITY AND WAIVER

Release for Em

Patient Name:	Date:
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I understand that chiropractic care is a safe and effective form of treatment for many musculoskeletal conditions, but as with any healthcare procedure, there are risks.

By signing this form, I acknowledge and agree to the following:

I have been informed of the nature of chiropractic treatment and potential risks, which may include temporary soreness, increased discomfort, and, in rare cases, injury to bones, joints, or nerves.

I release and hold harmless **Dr. Stefan Getzik, DC and Getzik Family Chiropractic, LLC** and its chiropractors, staff, and affiliates from any and all liability, claims, or damages arising from my participation in chiropractic care, except in cases of gross negligence or willful misconduct.

I understand that my participation is voluntary and I may stop treatment at any time.

Acknowledgment:

I have read this waiver, fully understand its terms, and sign it voluntarily.

Patient Signature over printed name

Date Signed

Witness Signature over printed name

Date Signed



PHOTO AND VIDEO *Release form*

I, _____, hereby grant and authorize **GETZIK FAMILY CHIROPRACTIC** the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and/or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph recording.

I understand and agree that these materials shall become the property of the **GETZIK FAMILY CHIROPRACTIC** and will not be returned.

I hereby hold harmless and release **GETZIK FAMILY CHIROPRACTIC** from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

By signing below, I hereby acknowledge that
understand the above release agreement.

I have completely read and fully

Client Signature over
printed name

Date Signed