Profile Information — Step 1 of 4

You are completing the following intake forms: Intake Form (June 2026)

You are filling out an intake form for

Patient Name

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

Only staff members can edit this information on an intake form.

First Name – *Required*

Last Name – *Required*

Email – *Required*

Preferred Name (if different)

Prefix / Title

Select an option...

Please provide at least one phone number. Your mobile number can be used to look up your Account.

Home Phone

US

Mobile Phone – *Required*

US

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

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

State – *Required*

Select a State...

Country – *Required*

United States

Zip Code – *Required*

Date of Birth – *Required*

Month

Select a month...

Day

XX

Year

XXXX

Sex – *Required*

Select an option...

Occupation

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of Referring Professional

Referring Professional Phone (if known)

Referring Professional Email (if known)

How Did You Hear About Us? – *Required*

Select an option...

Insurance Information — Step 2 of 4

You are completing the following intake forms: Intake Form (June 2026)

Your insurance policy

If you do not have insurance, please leave this blank Otherwise, please complete this section so we can try to get your insurance benefits before your appointment.

Insurer

Select an insurer

Questionnaires — Step 3 of 4

You are completing the following intake forms: Intake Form (June 2026)

Intake Form (June 2026)

Patient Information

Marital Status:

- [ ] Married
- [ ] Single
- [ ] Divorced
- [ ] Separated
- [ ] Widowed

Spouse's Name:

Number of Children:

Current Health Conditions

Reason for visit:

When did it start?

Have you received care for this problem? If yes, please explain:

How did the condition(s) first begin?

What makes the problem better?

What makes it worse?

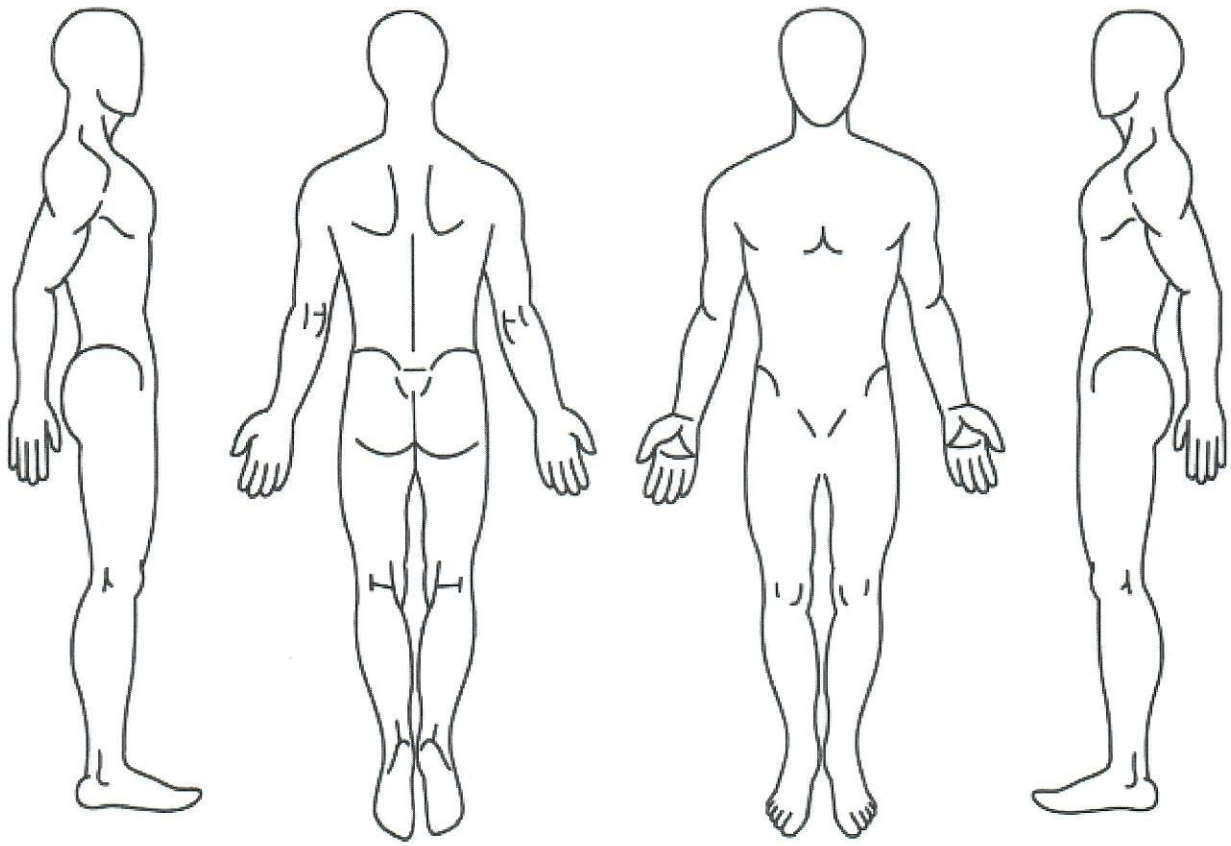
Is the condition:

- [ ] Getting Worse
- [ ] Improving
- [ ] No Change

Is the condition:

- [ ] Intermittent (on and off)
- [ ] Constant
- [ ] Unsure

Body Chart - Please mark areas of pain, stress, tension, or discomfort



Describe the pain:

- [ ] Aching
- [ ] Sharp
- [ ] Numb
- [ ] Dull
- [ ] Burning
- [ ] Tingling
- [ ] Deep
- [ ] Throbbing
- [ ] Other

Rate your pain level

0 1 2 3 4 5 6 7 8 9 10

For Women Only:

Are you pregnant?:
Due Date:
Are you currently nursing?

Your Health Goals

Describe your health goals:

Chiropractic History

What would you like to gain from chiropractic care?

- [ ] Symptomatic Relief
- [ ] Corrective Care
- [ ] Both

Have you ever visited a chiropractor before?

- [ ] Yes
- [ ] No

For what reason did you visit a chiropractor and did it help?

Health History

Indicate if YOU or any IMMEDIATE FAMILY members have any of the following:

- [ ] Rheumatoid Arthritis
- [ ] Diabetes
- [ ] Lupus
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Stroke
- [ ] Cancer

If you selected yes to any of the previous, please specify who has/had the condition:

For each of the conditions listed below, please check the box if you have had the condition in the past or currently:

- [ ] Headaches
- [ ] Neck pain
- [ ] Upper back pain
- [ ] Midback pain
- [ ] Low back pain
- [ ] Shoulder pain
- [ ] Arm pain
- [ ] Wrist pain
- [ ] Hand pain
- [ ] Upper leg pain
- [ ] Hip pain
- [ ] Knee pain
- [ ] Ankle/Foot pain
- [ ] Jaw pain
- [ ] Joint swelling
- [ ] Arthritis
- [ ] Rheumatoid arthritis
- [ ] General fatigue
- [ ] Vision problems
- [ ] Ringing in the Ears
- [ ] Memory problems
- [ ] Broken bones
- [ ] Pacemaker
- [ ] Dizziness
- [ ] High Blood Pressure
- [ ] Heart Attack/disease
- [ ] Chest pain
- [ ] Stroke
- [ ] Angina
- [ ] Kidney Stones
- [ ] Kidney disorders
- [ ] Loss of Bladder Control
- [ ] Painful Urination
- [ ] Bladder infection
- [ ] Prostate Problems (Men only)
- [ ] Abnormal weight change
- [ ] Loss of appetite
- [ ] Abdominal pain
- [ ] Ulcer
- [ ] Hepatitis
- [ ] Tumor
- [ ] Gall Bladder problems
- [ ] Sensitivity to light
- [ ] Cold hands/feet
- [ ] Liver disease
- [ ] Thyroid problems
- [ ] Asthma
- [ ] Sinus problems
- [ ] Diabetes
- [ ] Excessive thirst
- [ ] Frequent urination
- [ ] Tobacco Use
- [ ] Drug/Alcohol dependence
- [ ] Allergies
- [ ] Depression/Anxiety
- [ ] Lupus (SLE)
- [ ] Epilepsy
- [ ] Dermatitis/Eczema/Rash
- [ ] Concussion
- [ ] Hormonal replacement
- [ ] Birth Control Pills
- [ ] Pregnancy
- [ ] Cancer
- [ ] Muscular incoordination
- [ ] Loss of balance
- [ ] Loss of concentration
- [ ] Anemia
- [ ] Osteoporosis
- [ ] Other

Traumas: Physical Injury History

Have you every had any significant falls, surgeries, accidents or injuries as an adult?

- [ ] Yes
- [ ] No

If yes, please explain:

Have you ever been hospitalized?

- [ ] Yes
- [ ] No

If yes, why?

Notable childhood injuries?

Youth or college sports?

Describe any car accidents you've been in:

Current Emotional Stress:

- [ ] Home
- [ ] Work
- [ ] Financial
- [ ] Relationship
- [ ] Other

The doctor will be examining and treating you. Does physical contact make you uncomfortable?

- [ ] Yes
- [ ] No

Exercise Frequency:

- [ ] 1-2x/week
- [ ] 3-5x/week
- [ ] Daily
- [ ] Never

What types of exercise do you perform?

How do you normally sleep?

- [ ] Back
- [ ] Side
- [ ] Stomach

Do you wake up:

- [ ] Refreshed
- [ ] Stiff & Tired

Do you commute to work?

- [ ] Yes
- [ ] No

How many minutes per day do you commute to work?

How many hours per day do you typically spend sitting?

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each (1 = never, 5 = high):

Alcohol

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Water

1 2 3 4 5

Sugar

1 2 3 4 5

Dairy

1 2 3 4 5

Gluten

1 2 3 4 5

Caffeine

1 2 3 4 5

Processed Foods

1 2 3 4 5

Artificial Sweeteners

1 2 3 4 5

Sugary Drinks

1 2 3 4 5

Cigarettes/Tobacco

1 2 3 4 5

Recreational Drugs

1 2 3 4 5

Fast Food

1 2 3 4 5

Allergies:

Current Stress Levels

Select an option... low medium high

Medication List

Sports and hobbies, current and past, reasons for quitting

Diet, habits, exclusions and supplements

Surgeries/outcomes

Consents — Step 4 of 4

You are completing the following intake forms: Intake Form (June 2026)

Communication

Appointment Notifications and Reminders

Email

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

- [ ] **I would like email notifications of new, cancelled, and rescheduled appointments**

- [ ] **Email 24 hours 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) 24 hours before appointment**

- [ ] **Text Message (SMS) 2 hours before appointment**

News and Special Promotions

- [ ] **Yes, I would like to receive news and special promotions by email**

Intake Form (June 2026) — Consents

Accuracy of Information – *Required*

- [ ] **I certify that the above medical information is correct to the best of my knowledge, and I allow Dr. Vitale to examine me for further evaluation.**

Privacy and Sharing of Information – *Required*

I authorize Great Lakes Chiropractic and Dr. Vitale to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] **I agree**

Cancellation and No-Show Policy – *Required*

LOW-WAITING ADJUSTMENT HOURS
These hours are to provide patients with prompt, complete care that does not require waiting. To reduce waiting, patients are asked to schedule their appointments in advance, make payments in advance, and fill out their patient notes in advance of seeing the doctor. Patients with new injuries should change an appointment during these hours to Consultation/Examination hours to have the time with the doctor they need. **Failing to show up for an appointment will result in a $25.00 no-show fee. Failing to reschedule your appointment with 24 hours' advance notice will result in a $15 late-cancellation fee.** We understand that unforeseen circumstances can sometimes arise, leading to missed appointments. However, missed appointments can negatively impact your health by delaying necessary care and can also affect our ability to provide timely care to other patients. Exceptions to this policy are granted at the discretion of our office and must be documented

CONSULTATION/EXAMINATION HOURS
These are for consultations, report of findings, examinations, re-exams, re-evaluations, discussions regarding diet, exercise, finances, x-rays, etc.; These are for visits that require more time.
These appointment times are generally 30 minutes or longer and, as such, any missed appointments without 24 hours advance notice will result in a $50.00 cancellation fee.

We recognize that emergencies occur and an appointment might not be able to be kept. In such a case we request the following:

1. Call as soon as you can.
2. Reschedule your make-up appointment the same day, the next day or within the next week.
3. If treatment is missed and not made up within 7 days you will most likely need one visit more than the recommended series. This will cost you time and money. **Remember your results are based on the number of kept appointments per week.**

Great Lakes Chiropractic appreciates every one of our patients and is dedicated to providing you with the best care possible.

☐ **I understand and agree**

Open-Room Adjusting – *Required*

At Great Lakes Chiropractic, we utilize open-room adjusting in which two or more adjusting tables are side by side, and other patients may be in the room being treated. The efficiency allows us to greatly shorten waiting time, and the doctor's advice on healthy living is beneficial for all to hear. Personal or embarrassing topics will not be discussed in an open forum. If you wish to discuss a private matter with the doctor, please notify a staff member so you may be seen separately in a private consultation room.. It is not necessary for you to tell the employee the subject of this discussion.

Chiropractors do not engage in the medical practice of diagnosing and treating disease. The chiropractor's one goal is to examine the patient's spine and—and should a subluxation be detected—correct it by means of a chiropractic adjustment. The adjustment is not meant to be a panacea for all disease or a specific treatment for any particular disease. Regardless of what the disease is called, the chiropractor does not offer to diagnose, heal, or treat it, nor does the chiropractor offer advice regarding the treatment of disease.

☐ **I understand and agree**

Financial Responsibilities, Authorizations, and Releases – *Required*

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance and/or non-covered service.
- Co-payments are due at time of service.
- In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Dr. Angela Vitale, DC, LLC of Great Lakes Chiropractic on my behalf for any services furnished to me by the provider.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Dr. Angela Vitale, DC of Great Lakes Chiropractic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to any other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Dr. Angela Vitale, DC of Great Lakes Chiropractic. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

☐ **I understand and agree**

Credit Card Processing Fees – *Required*

All debit, credit, and HSA/Flexible spending accounts will include an additional 3.5% processing surcharge on transactions.

To avoid these fees, we will accept CHECK or CASH.

Please make checks payable to Dr. Angela Vitale, DC LLC.

Thank you for your understanding!

☐ **I understand and agree**

Signature – *Required*

Draw ○ **Type**

Submit Intake Form