Chiropratica Ceresio
Via Ceresio 17
22018 Porlezza
Tel: 3751274472

INTAKE FORM & MEDICAL HISTORY

Name: _____

Last name: _____

Date of birth: _____

	L	L	L	L	L	L	#	#	L	#	#	L	#	#	#	L
Cod fisc:																

Address: _____

City and zip code: _____

Telephone number: _____

Email: _____

Profession: _____

How did you find us? _____

INFORMATION AND CONSENT TO THE PROCESSING OF PERSONAL DATA
(EU Regulation 2016/679 – GDPR)

1. Data controller
The owner and data controller is: Steven Lia, Doctor of Chiropractic (DC), with headquarters at Chiropratica Ceresio, Via Ceresio 17, 22018 Porlezza

2. Purpose of processing
Personal and health data are processed for:
-the provision of chiropractic services and related activities;
-administrative and fiscal management;
-legal compliance;
-(optional) sending of reminders and informational communications.

3. Legal basis
The processing is carried out for:
-requested healthcare services (Art. 9.2.h GDPR);
-regulatory obligations (Art. 6.1.c GDPR);
-consent of the data subject when necessary.

4. Methods of processing
The data is processed in a lawful, correct, and secure manner, including with electronic tools.

5. Data retention
Data is retained for the time necessary to perform services and for legal obligations (usually 10 years).

6. Data disclosure
Data may be disclosed to:
-healthcare/administrative staff;
-external consultants (e.g., accountants, IT specialists);
-public bodies in the cases provided for.
The data will not be disclosed or transferred abroad.

7. Rights of the data subject
You may request: access, rectification, erasure, restriction, objection, withdrawal of consent, as well as lodge a complaint with the Data Protection Authority.

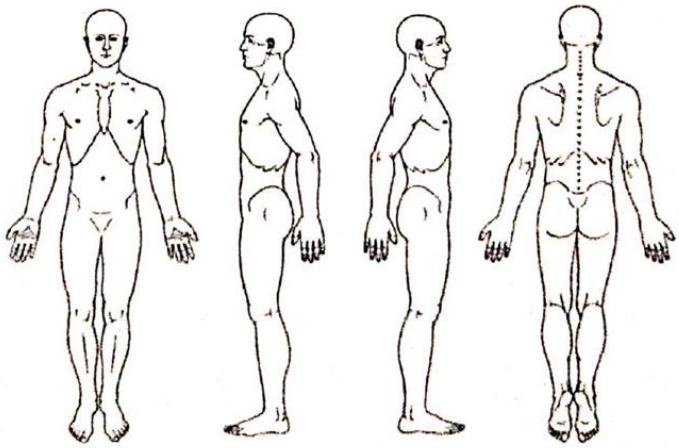
CONSENT TO THE PROCESSING OF PERSONAL DATA
I declare that I have received the information notice and:
☐ I consent to the processing of my personal and health data.
☐ I do not consent (it will not be possible to proceed with the service).

Patient signature: _____
Date: ___ / ___ / _____

Consent for communications (optional)
☐ I consent to receiving reminders/communications via email or SMS.
☐ I do not consent

Patient signature: _____
Date: ___ / ___ / _____

Please indicate the location of your symptoms on the chart.



Please indicate the reasons that brought you to Chiropratica Ceresio, listing separately any neck, upper back, and lower back issues. If you have more than 5 complaints, please request additional registration forms.

Symptom no. 1: _____

How long have you been experiencing it? _____ days _____ weeks _____ months _____ years

Is this the first time you have experienced it? Yes ☐. If not, when was the first time? _____

How severe is it on a scale of 1 to 10? _____ / 10

What is the nature of the complaint?
Tension/pulling☐ Stinging☐ Burning ☐ Tingling☐ Numbness☐ Oppression☐

Does the complaint radiate to other parts of the body?
No, it is localized☐ Shoulder☐ Elbow☐ Hand☐ Buttock☐ Knee☐ Foot☐ Other _____

When does it occur? At a particular time of day?
Morning☐ Afternoon☐ End of the day☐ Other _____

Symptom no. 2: _____

How long have you been experiencing it? _____ days _____ weeks _____ months _____ years

Is this the first time you have experienced it? Yes ☐. If not, when was the first time? _____

How severe is it on a scale of 1 to 10? _____ / 10

What is the nature of the complaint?
Tension/pulling☐ Stinging☐ Burning ☐ Tingling☐ Numbness☐ Oppression☐

Does the complaint radiate to other parts of the body?
No, it is localized☐ Shoulder☐ Elbow☐ Hand☐ Buttock☐ Knee☐ Foot☐ Other _____

When does it occur? At a particular time of day?
Morning☐ Afternoon☐ End of the day☐ Other _____

Symptom no. 3: _____

How long have you been experiencing it? _____ days _____ weeks _____ months _____ years

Is this the first time you have experienced it? Yes ☐. If not, when was the first time? _____

How severe is it on a scale of 1 to 10? _____ / 10

What is the nature of the complaint?
Tension/pulling☐ Stinging☐ Burning ☐ Tingling☐ Numbness☐ Oppression☐

Does the complaint radiate to other parts of the body?
No, it is localized☐ Shoulder☐ Elbow☐ Hand☐ Buttock☐ Knee☐ Foot☐ Other _____

When does it occur? At a particular time of day?
Morning☐ Afternoon☐ End of the day☐ Other _____

Symptom no. 4: _____

How long have you been experiencing it? _____ days _____ weeks _____ months _____ years

Is this the first time you have experienced it? Yes ☐. If not, when was the first time? _____

How severe is it on a scale of 1 to 10? _____ / 10

What is the nature of the complaint?
Tension/pulling☐ Stinging☐ Burning ☐ Tingling☐ Numbness☐ Oppression☐

Does the complaint radiate to other parts of the body?
No, it is localized☐ Shoulder☐ Elbow☐ Hand☐ Buttock☐ Knee☐ Foot☐ Other _____

When does it occur? At a particular time of day?
Morning☐ Afternoon☐ End of the day☐ Other _____

Symptom no. 5: _____

How long have you been experiencing it? _____ days _____ weeks _____ months _____ years

Is this the first time you have experienced it? Yes ☐. If not, when was the first time? _____

How severe is it on a scale of 1 to 10? _____ / 10

What is the nature of the complaint?
Tension/pulling☐ Stinging☐ Burning ☐ Tingling☐ Numbness☐ Oppression☐

Does the complaint radiate to other parts of the body?
No, it is localized☐ Shoulder☐ Elbow☐ Hand☐ Buttock☐ Knee☐ Foot☐ Other _____

When does it occur? At a particular time of day?
Morning☐ Afternoon☐ End of the day☐ Other _____

MEDICAL HISTORY

Please indicate any accidents such as falls, fractures, traffic accidents, surgeries, or hospitalizations. If you have none, write **NONE**.

Accidents, Fractures (dates): _____

_____

Surgeries or hospitalizations (dates): _____

_____

Have you had any X-rays, MRIs, or blood tests recently? _____

Have you consulted other healthcare professionals about your condition? Who? ☐No ☐Yes ____

Does anyone in your family have similar problems, symptoms, or conditions? ☐No ☐Yes,____

Have you recently experienced night sweats or unexplained weight loss? ☐No ☐Yes

MEDICATIONS

Please list all medications you are currently taking, including herbal remedies, vitamins, or dietary supplements.

Name	Dose	Frequency	Name	Dose	Frequency
_____			_____		
_____			_____		

LIFESTYLE

Do you exercise? ☐Yes ☐No. What kind? How often? _____

Do you eat a healthy diet? ☐Yes ☐Could be better ☐No

How much water do you drink per day? (Liters) _____

Do you drink alcohol? ☐Yes ☐No. How much? _____

Do you smoke? ☐Yes ☐No. How much? _____

Do any of your health issues limit your daily activities? Which activities? _____

How would you rate your daily stress level? ___/10

How do you sleep? ☐Well ☐Poorly. How many hours per night? _____ / night.

Do your health issues interfere with your sleep? ☐No ☐Yes, _____

☐I understand that chiropractic care involves the identification, analysis, and correction of vertebral subluxation.

☐I am aware that vertebral subluxation occurs when one or more spinal vertebrae lose proper structure/function, causing interference with the nervous system.

☐I am aware that chiropractic care is based on clinical evidence of subluxations, which are identified through specific tests and analyses, and NOT on the presence or absence of pain, abnormal joint mobility, or abnormal curvature of the spine.

☐I am aware that a treatment session consists of chiropractic manipulative therapy (adjustments) aimed at realigning the spine and correcting vertebral subluxation complexes. This therapy is administered through HVLA (high velocity, low amplitude) manual chiropractic adjustments or with the aid of MAT (mechanically assisted techniques: activator, drops, orthopaedic blocks).

☐The chiropractor may perform a direct manual examination of areas of the body related to the initial clinical data provided by the patient in order to obtain the best information.

☐The chiropractor will inform me about the process to follow to achieve better health and well-being, assess my condition, and formulate a treatment proposal based on the results of the initial examination.

☐I understand that the duration of an adjustment session at the Chiropratica Ceresio clinic generally varies from 10 to 15 minutes. The session ends once the necessary chiropractic adjustments have been made to correct the vertebral subluxations. The use of additional soft tissue or joint techniques, such as trigger point therapy, Thumper, Arthrostim technology, or PNF stretching, is only performed if the practitioner deems it necessary and relevant to complement the chiropractic adjustment session.

☐I understand that each patient reacts differently to the first adjustment sessions. Some patients experience immediate improvement, others initially experience no symptomatic change, while others may experience discomfort in the form of stiffness, increased muscle tension, or an initial increase in symptoms, which typically subsides over time (also known as a Reaction).

☐I have been informed that other very rare complications of chiropractic treatment include sprains, bone fractures (rib fractures), and vascular injuries. I understand that the likelihood of complications following chiropractic care is extremely low. The risk of vascular injury following a cervical adjustment is estimated to be between one in a million and one in twenty million, depending on the source used as a reference.

☐If you need to change your scheduled appointments, our office requires at least 24 hours' notice. Any missed appointments without adequate notice will be subject to a 60 euro penalty. After three missed appointments, your doctor may discontinue treatment.

Date: _____ Signature: _____