PAST AND PRESENT HEALTH HISTORY

Name and Address of Family Doctor: _____

Please check "YES" if you presently have it, "NO" never had it or "HAD" if you had it in the past

Anemia	YES	NO	HAD
Arthritis			
Asthma			
Bronchitis			
Cancer			
Diabetes			
Lung Disease			
Epilepsy			

Thyroid Dis.	YES	NO	HAD
Heart Disease			
High Blood Pr.			
Lung Disease			
H. Cholesterol			
Kidney Dis.			
Lung Disease			
MS			

Migraines	YES	NO	HAD
Headaches			
Pinched Nerve			
Allergies			
Prostate			
ED			
Breast Dis.			
Female Rep.			

List any other health conditions:_____

_____

Exercise Habits: ____None ____Moderate ____Daily
Work Activity: ____Sitting ____Standing ____Heavy Labor
Other Habits: ____Smoking ____Alcohol ____Caffeine Coffee

Any Allergies?_____

_____

Any history of accidents?

_____

_____

_____

List of current medications:

_____

_____

_____

Are you taking supplements?

_____

_____

_____

FOR DOCTORS USE ONLY

_____

_____

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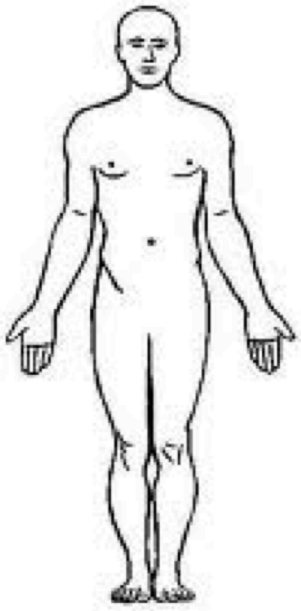

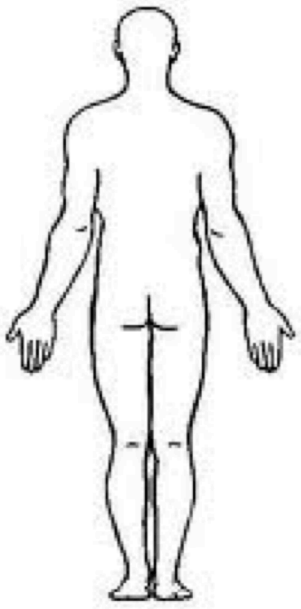

CHIROPRACTIC REGISTRATION & HEALTH HISTORY FORM

1 PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____/_____/_____ Age: _____

SS# _____-_____-_____ Sex: M___ F___

____Married ____Single ____Widowed ____Minor

Employer: _____

Occupation: _____

Spouse's Name: _____

Who referred you? _____

Have you been to a Chiropractor Before? _____

Have you heard of the term "Subluxation"? _____

2 CONTACT INFORMATION

Cell Phone: _____

Does your cell receive text messages? _____

Home Phone: _____

Work Phone: _____

Email:_____

Emergency Contact:

Name:_____

Relationship:_____

Contact Phone:_____

3 ACCIDENT INFORMATION

Type: Auto___ Work ___ *Other* Date_____

Was the accident reported? _____

Do you have an accident report? _____

Anyone else in the accident?_____

Attorney Name: _____

Attorney Phone: _____

4 INSURANCE INFORMATION

Insurance Co. _____

Subscriber:_____

Ins ID#:_____

Group/Cat#_____

Subscriber SS#_____

Relationship to Patient: _____

Birthdate: _____/_____/_____ Age: _____

I, the undersigned direct my insurance carrier to assign directly to Dr. Vetere all insurance payments for services rendered.

Signed: _____

5 PATIENT CONDITION

I'm here for the Wellness Program : **Y____ N____**

Major Complaints: _____

_____

_____

When did symptoms appear?_____

I you condition getting worse?_____

Pain Scale (1-10) _____ (1-Least / 10-Severe)

How often do you feel the pain?_____

Does it interfere with: Work ___ Sleeping ___

Daily Routine ___ Recreation __ Concentration ___

The Following increase pain: Sitting __ Standing __

Walking __ Bending __ Lifting __ Lying down __

Indicate areas of pain type:

___ Sharp

___ Dull

___ Numb

___ Tingling

___ Shooting

___ Stiffness

___ Swelling