Vitality
INSTITUTE OF HEALTH

CONFIDENTIAL PATIENT INFORMATION

DATE_____

NAME_____AGE_____ DOB_____SOCIAL SECURITY #_____

ADDRESS_____CITY_____ZIP_____

HOME PHONE_____ CELL _____ WORK_____

EMAIL _____ MARITAL STATUS M S W D HOW MANY CHILDREN? _____

OCCUPATION_____EMPLOYER_____

NAME OF SPOUSE_____ OCCUPATION_____

PATIENT'S NEAREST RELATIVE_____PHONE_____

REFERRED BY _____

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ____YES _____NO

DATE SYMPTOMS APPEARED OR ACCIDENT HAPPENED_____

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ____YES _____NO

IF YES, WHEN AND DESCRIBE_____

HAVE YOU LOST ANY DAYS FROM WORK ____YES _____NO DATE OF LAST PHYSICAL EXAM_____

FEMALE – ARE YOU PREGNANT? ____YES _____NO

WHAT OPERATIONS HAVE YOU HAD?_____

SERIOUS ILLNESSES_____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ____YES _____NO IF YES, DOCTOR'S NAME_____

DO YOU NOW TAKE VITAMINS/MINERALS? ____YES _____NO

DO YOU THINK YOU MAY NEED TO TAKE VITAMINS/MINERALS? ____YES _____NO

ARE YOU WEARING?

_____HEEL LIFTS

_____SOLE LIFTS

_____INNER SOLES

_____ARCH SUPPORTS

HABITS	HEAVY	MODERATE	LIGHT	NONE
ALCOHOL				
COFFE				
TOBACCO				
DRUGS				
EXERCISE				
SLEEP				
APPETITE				

WHAT MEDICATIONS ARE YOU TAKING? _____

PURPOSE OF THIS APPOINTMENT (MAJOR

COMPLAINT)_____

_____

_____

_____

SEE OTHER SIDE

SYMPTOMS – PLEASE CHECK ALL THAT APPLY

HEAD:

- ☐ HEADACHE
- ☐ ENTIRE HEAD
- ☐ BACK OF HEAD
- ☐ FOREHEAD
- ☐ TEMPLES
- ☐ MIGRAINE
- ☐ HEAD FEELS HEAVY
- ☐ LOSS OF MEMORY
- ☐ FAINTING
- ☐ LIGHTS BOTHER EYES
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ LOSS OF BALANCE
- ☐ DIZZINESS
- ☐ LOSS OF HEARING
- ☐ PAIN IN EARS
- ☐ RINGING IN EARS
- ☐ BUZZING IN EARS

NECK:

- ☐ PAIN IN NECK
- ☐ PAIN WITH MOVEMENT
- ☐ PINCHED NERVE IN NECK
- ☐ NECK FEELS OUT OF PLACE
- ☐ STIFF NECK
- ☐ MUSCLE SPASMS IN BACK
- ☐ GRINDING SOUNDS IN NECK
- ☐ GRATING SOUNDS IN NECK
- ☐ POPPING SOUNDS IN NECK
- ☐ ARTHRITIS IN NECK

SHOULDERS:

- ☐ PAIN IN SHOULDER JOINT
- ☐ PAIN ACROSS SHOULDERS
- ☐ BURSITIS (R-L)
- ☐ ARTHRITIS (R-L)
- ☐ CAN'T RAISE ARM:
  - ABOVE SHOULDER LEVEL
  - OVER HEAD
- ☐ TENSION IN SHOULDER (R-L)
- ☐ MUSCLE SPASM IN SHOULDERS

MID-BACK

- ☐ PAIN
- ☐ PAIN BETWEEN SHOULDER BLADES
- ☐ SHARP STABBING PAIN IN MID-BACK
- ☐ MUSCLE SPASMS

LOW BACK

- ☐ PAIN
- ☐ PAIN IS WORSE WHEN:
  - WORKING
  - LIFTING
  - STOOPING
  - STANDING
  - SITTING
  - BENDING
  - COUGHING
- ☐ PINCHED NERVE IN LOW BACK
- ☐ SLIPPED DISK
- ☐ LOW BACK FEELS OUT OF PLACE
- ☐ MUSCLE SPASMS
- ☐ ARTHRITIS

ABDOMEN

- ☐ NERVOUS STOMACH
- ☐ NAUSEA
- ☐ GAS
- ☐ CONSTIPATION
- ☐ DIARRHEA

GENERAL

- ☐ NERVOUSNESS
- ☐ IRRITABLE
- ☐ DEPRESSED
- ☐ FATIGUE
- ☐ GENERALLY RUN DOWN
- ☐ LOSS OF SLEEP
- ☐ LOSS OF WEIGHT

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?

_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ____YES _____NO _____CONSTANT _____COMES AND GOES

THIS CONDITION INTERFERES WITH MY _____WORK _____DAILY ROUTINE _____SLEEP _____OTHER

HOW LONG HAS IT BEEN SINCE YOU FELT REALLY GOOD? _____

WHAT DO YOU BELIEVE IS WRONG WITH YOU? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? _____

DESCRIBE _____

PAYMENT IS EXPECTED AT TIME OF VISIT

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____

ARE YOU INSURED _____YES _____NO COMPANY_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, and credited to my account. However I clearly understand and agree that all services rendered me is charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If I fail to pay, the doctor shall have the right at his/her option to collect a delinquency charge, interest and/or accelerate the maturity total of payments and I shall pay all attorney fees, court costs and disbursements made by him to collect this amount. Any amount remaining unpaid after the expiration of the maturity date shall draw interest at the highest legal contract in this state.

SIGNATURE _____ DATE_____

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE_____ DATE_____

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