Name: ________________________________

HEALTH INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Age: __________ Birth Date: ______/______/_______ Gender: M F Marital Status: S M D W

Home Address: ________________________________ Home Phone: ( ) ______________________

City, State, Zip: ________________________________ Work Phone: ( ) ______________________

Email Address: ________________________________ Cell Phone: ( ) ______________________

Names of Children: ____ Ages: ____________________

Occupation: ____ Employer Name: ____________________

Spouse's Name: ________________________________ Phone: ( ) ____________________________

Spouse's Employer: ____________________________ Occupation: ____________________________

Who can we thank for referring you here today? ____

SYMPTOMS? (BODY SIGNALS)

Health Concerns: List Worst First	Pain Severity: 1=Mild 10=Unbearable	Did this start with an injury?	How long have you had this? Date?	Have you had this before? When?	Is this constant or comes/goes?
1					
2					
3					
4					

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: ____________________

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe:__________________________

Type of Pain (circle): Sharp Dull Ache Burn Throbbing Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ☐ Arm ☐ Leg ☐ None Is this condition getting worse? ☐ Yes ☐ No

How often do you experience the pain throughout the day? 100% 75% 50% 25% 10% Only with Activity

RESTRICTED ACTIVITY: Does complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine. How do your health concerns affect your daily life (working, getting dressed, walking, sitting, sleeping, exercising, etc.)?

____

Who have you seen for your condition (medical doctor, chiropractor, other)?______________________________

Please list any **medications** currently taking and for what : ____

____

Please list all past **broken bones, surgeries or hospitalizations**: ____

____

Please list all previous **auto accidents or significant trauma**: ____

EXPERIENCE WITH CHIROPRACTIC:

Have you seen a Chiropractor before? ☐ Yes ☐ No Reason for visits: ___________________________________

Favorable outcomes? ☐ Yes ☐ No Explain: ____

Are you aware of any of your poor posture habits? ☐ Yes ☐ No Explain: ____________________________________

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No Have their spines been checked?

Explain: ____

HEALTH LIFESTYLE:

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _______________________

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _______________________

Do you smoke? Yes No How much? ____

Do you drink alcohol? Yes No How much / week? ____

Do you take any supplements (i.e. vitamins, minerals, herbs)? ____

ACKNOWLEGMENTS: **Please read each statement and initial your agreement on the left.**

Pregnancy Release

______ This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: (MM/DD/YYYY) __________________

Consent to Spinal Imaging

______ I hereby grant Vertical Chiropractic permission to perform an x-ray evaluation of my spine if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Insurance Information

______ I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Privacy Policy

______ I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

______ Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

By signing below, you are acknowledging that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity, or cause of your health concern.

____ ____

Patient Signature Date Doctor Signature Date

FAMILY HEALTH HISTORY

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening the whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck?

☐ **Yes** ☐ **No**

Please check off any of the conditions below that you and your family have or have had in the past:

*** Write C if current issue or P if past issue**

	You	Spouse	Children	Mother	Father
Asthma / Allergies					
Arthritis					
TMJ					
Acid Reflux					
Epilepsy / Seizure					
Ulcers					
Dizziness					
Headaches					
Vertigo					
Neurological Problem					
Menstrual Irregularity					
Nausea					
Lupus					
Fatigue					
Numbness					
Ear Infection					
Sciatica					
Heart Condition					
Migraines					
Thyroid Problem					
Kidney Problem					
Liver Disease					
Fainting					
Disc Problem					
Neck / Back Pain					
Irritable Bowel					
Digestive Problem					

Circle any of the following conditions you currently have or in the past:

STROKE CANCER HEART DISEASE SEIZURES SPINAL FRACTURE SCOLIOSIS DIABETES

RHEUMATOID ARTHRITIS AIDS/HIV GENETIC DISEASE OTHER _________________ OR ☐ **NONE**

Patient Signature _____________________ Date

Doctor Signature _____________________ Date