



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):

Spine & Health Conditions: List Worst First	Pain Severity: 1=Mild 10=Unbearable	Mechanism of your 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): Ache Burn Dull Numb Sharp Stabbing Throbbing Tingling Tightness

Does the Pain Radiate into your: L R Arm L R 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 Lifting Sitting/Standing. How do your health concerns affect your daily life: (circle all that apply) bending over, caring for family, climbing stairs, driving, exercising, household chores, looking over shoulder, lying down, reaching, bathing, use computer, walking, yard work

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

Please list any **medications** currently taking and for what conditions: _____

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)? _____

ACKNOWLEDGMENTS: 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

