VITALITY
SPINE AND REHAB

CONFIDENTIAL PATIENT INFORMATION

FIRST- AND SECOND-DAY PROCEDURES

Welcome to Vitality Spine and Rehab! We strive to offer the highest quality of Chiropractic Care in a caring atmosphere. It is our honor and pleasure to save you.

On your first day we will perform an examination and take your initial x-rays. You will not receive your first adjustment today (except in emergency cases). This day is part of the information gathering that is necessary to give you the highest quality of care. Please do not hesitate to ask any questions as we complete today's procedures.

After you complete your confidential history form, we will call you back for your spinal exam where we will assess your current spinal condition. You will then be taken to the x-ray room for preliminary x-rays.

Scheduling your second visit will be the last part of today's visit. Your second visit will approximately 1 hour long, so make sure you allow enough time. We would like to schedule you within the next couple of days so that you can begin to experience the benefits of Chiropractic Care as soon as possible.

You second day will consist of additional exam work and the completion of your x-rays. After concluding your x-rays there will be a meeting with the doctor for a complete report of findings. If you qualify as a patient, you and the Doctor will discuss your program of care to help you get the best result as soon as possible. You will then be adjusted followed by a short resting period to relax after your first adjustment.

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Patient Data

Name: _____ DOB: _____ / _____ / _____ Today's Date: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Soc Sec. #: _____ Driver's License #: _____

Home #: ( ) _____ Work #: ( ) _____ Ext.: _____ Fax #: ( ) _____

Beeper/Cell #: ( ) _____ Email: _____

Occupation: _____ Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

☐ Male ☐ Female # of Kids: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Spouse: _____ Name of Kids: _____

Reason for consulting our office? _____

_____

Referred By: _____ Do you have health insurance? ☐ Yes ☐ No

* Please check if you are here for any of the following:

☐ Motor Vehicle Accident ☐ Work Injury ☐ Other Injury: _____

Your Health Profile

Why this form is important - As a family wellness-oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have face in your lifetime, thus allowing us to better assess your current status and more accurately determine your true health potential.

The Beginning Years - Research is showing that many of the health challenges that occur later in life have their origins during developmental year, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History – Please check those items that apply you

- ☐ Mother smoked/drank/drugs during pregnancy
- ☐ C-Section
- ☐ Labor Induced
- ☐ Epidural/Meds in Labor
- ☐ Forceps Delivery
- ☐ Complications
- ☐ Breech Vaginal Delivery
- ☐ Vacuum Extractor used
- ☐ Others: _____

Childhood Years (Age 0-17 Yrs) – Please check those items that apply to you

- ☐ Childhood Illnesses
- ☐ Car Accident(s)
- ☐ Antibiotics/Other Meds
- ☐ Serious Falls
- ☐ Surgery/Stitches
- ☐ Vaccinated
- ☐ Active in Sports
- ☐ Alcohol/Drug Abuse
- ☐ Under Chiropractic Care
- ☐ Very Inactive
- ☐ Smoker
- ☐ Broken Bones
- ☐ Others: _____

Adult Years (Age 18 to present) – Please check those items that apply to you

- ☐ Present Smoker
- ☐ Work Injury
- ☐ Poor/Inadequate Diet
- ☐ Former Smoker
- ☐ High Job Stress
- ☐ No Exercise
- ☐ OTC/Prescription Meds
- ☐ High Personal Stress
- ☐ Flat Feet
- ☐ Alcohol Use
- ☐ Sit a lot
- ☐ Wear Orthotics/Lifts
- ☐ Surgery/Stitches
- ☐ Drive a lot
- ☐ Severe Health Problems
- ☐ Play Sports
- ☐ Poor Sleep
- ☐ Hard Falls
- ☐ Car Accidents
- ☐ Not Enough Sleep
- ☐ Broken Bones
- ☐ Other Injuries: _____

Have been under chiropractic care in the past – How long ago was your last adjustment? _____

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Addressing the issues that brought you to our office

Chief Complaints: _____

How has this affected your life? _____

_____

If you have pain, is it… ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Travelling
☐ Radiating ☐ Mild ☐ Moderate ☐ Moderately Severe ☐ Intolerable

Since it began, is it… ☐ About The Same ☐ Getting Better ☐ Getting Worse ☐ Variable

What makes it worse? _____

What makes it better? _____

Does it interfere with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting
☐ Exercise ☐ Hobbies ☐ Leisure Activities

Did you have an injury? ☐ Yes ☐ No

If Yes, please explain: _____

_____

How long have you had this problem? _____

Is there a time of day that it is worse typically? ☐ Yes ☐ No

If Yes, when? _____

Other doctors/treatments you've tried for this problem (Please List):

☐ Chiropractor: _____

☐ Medical Doctor: _____

☐ Others: _____

List all medications and/or supplements: _____

_____

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Please check all reoccurring or severe symptoms you have ever had, even if they do not seem related to your current problem(s):

- ☐ Headaches/Migraines
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Pins & Needles in Legs/Feet
- ☐ Loss of Taste
- ☐ Hot Flashes
- ☐ Recurring infection
- ☐ Upset Stomach
- ☐ Cold Sweats
- ☐ Infertility/Impotence/Miscarriage
- ☐ Fatigue
- ☐ Light Bothers Eyes
- ☐ Pins & Needles in Arms
- ☐ Depression
- ☐ Problems Urinating
- ☐ Loss of Smell
- ☐ Irritability/Mood Swings
- ☐ Heartburn/Reflux
- ☐ Dizziness/Vertigo
- ☐ Neck Stiffness/Pain
- ☐ Menopause
- ☐ Buzzing/Ringing in ears
- ☐ Cold hands
- ☐ Pre-Menstrual Syndrome
- ☐ Sinus Problems/Allergies
- ☐ Cold feet
- ☐ Ulcers
- ☐ Nervousness/Anxiety
- ☐ Diarrhea/Constipation/Gas
- ☐ Numbness in fingers
- ☐ Foot problems
- ☐ Others: _____

Family Health Profile – In our office, we are not only interests in your health & well being but also in that your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Others: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the Doctors of Vitality Spine and Rehab and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment, I certify that the above information is true and correct.

_____ _____/_____/_____

Signature Date

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