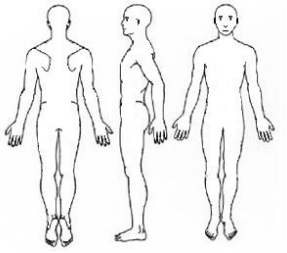
VITALITY CHIROPRACTIC FAMILY PRACTICE

PATIENT HISTORY

MALE/FEMALE DATE_____
NAME_____ DATE OF BIRTH_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
PHONE (H)_____ (W)_____ CELL:_____
EMAIL_____ SOCIAL SECURITY # _____
HOW DID YOU HEAR ABOUT US? _____
ATTORNEY NAME (FOR CAR ACCIDENTS) _____ PHONE #_____

CHIEF COMPLAINT

NECK PAIN HEADACHES MID-BACK PAIN LOW BACK PAIN ARM (R/L) SHOULDER(R/L) LEG (R/L)
OTHER:_____



Circle above the site of your pain(s)

PAIN RADIATES FROM_____ TO _____
ONSET DATE_____ GRADUAL SUDDEN
WHAT MAKES IT BETTER?_____
WHAT MAKES IT WORSE?_____
QUALITY OF PAIN? SHARP DULL ACHY BURNING DEEP
OTHER_____
Worse in: Morning Afternoon Night Same all day
Pain level: (better) 1 2 3 4 5 6 7 8 9 10 (worse)
Doctores notes _____
_____

Occupation_____
Is this injury work related? __Yes __No Is this injury an auto accident? __Yes __No
Describe your stress level at work? 1 2 3 4 5 6 7 8 9 10
Low High

Health History- Please check any conditions that you have been diagnosed with

___ Abdominal pain	___Difficulty breathing	___ Kidney stone
___ Arthritis	___ Dizziness	___ Liver disease
___ Bloody stool	___ Ear ache	___ Loss of sleep
___ Bruise easily	___ Eye problems	___ Low blood pressure
___ Chest pain	___ Fatigue	___ Mental illness
___ Constipation	___ Fever	___ Nausea
___ Depression	___Headaches	___ Tremors
___ Diarrhea	___ Hypertension	___ Weight loss

Family History- Please check any conditions that you or any blood relative has been diagnosed with

__ Arthritis	__Neurological disorder
__ Autoimmune disease	__Osteoporosis
__ Cancer	__ Respiratory disease
__ Diabetes	__ Stroke
__Heart disease	__ Thyroid disease
__High cholesterol	Other_____
__ Hypertension	

Have you sought any treatment from other healthcare provder for the same complaint? ____ Yes ___ No
If Yes, what was the treatment received? _____
Have any Xray or MRI been performed? _____ Yes __No
If yes, please indicate _____

Social History

Are you sexually active? ___ Yes ___ No
Do you smoke? __Yes ___ No __Use to How many per day?____
How many hours of sleep per night? _____
Do you exercise? __Yes ___ No How often? _____
Do you do any recreational drugs? ___ Yes ____No What kind?_____
Do you drink? __Yes __No How often? _____
How would you rate your diet? 1 2 3 4 5 6 7 8 9 10

List all the surgeries, hospitalizations and injuries you have had
_____
_____

List all the medications or supplements you are taking
_____
_____

Have you ever had chiropractic care before? _____ Yes _____ No
If yes, please provide:
Chiropractors name_____
Reasons for seeking care _____
Last visit _____
Results _____ Good _____ Fair _____ Poor

Patient Signature _____ Date _____

I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.