VITALITY CHIROPRACTIC FAMILY PRACTICE

PATIENT INTAKE FORM DATE_____

NAME_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE (H)_____ (W)_____ CELL:_____

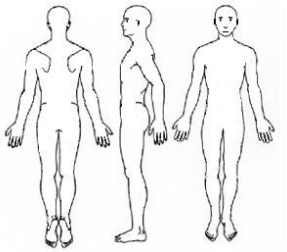
EMAIL_____ SOCIAL SECURITY # _____

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.

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Activities Discomfort Scale

Please mark with an X all that apply

Activity	Doesn't Hurt At All	Hurts a little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
Walking					
Sitting					
Bending					
Standing					
Sleeping					
Lifting					
Running or jogging					
Climbing stairs					
Carrying					
Pushing and pulling					
Driving					
Dressing					
Reading					
Watching TV					
Household chores					
Gardening					
Sports					
Employment					

Total_____

Patient signature_____ Date_____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT & CARE

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If this occurs, I will apply ice to the area (as instructed) and rest. If I am concerned about this discomfort or develop new symptoms, I can call the clinic phone number 24 hours a day and reach the doctor on call for emergency attention. If out of town, or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside this office (laboratory or other diagnostic procedure) I understand the doctor will notify me of the results when the report becomes available.
I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapy and if necessary, diagnostic radiographs (x-rays) by the doctor of chiropractic in this office or anyone in this office authorized by the doctor of chiropractic.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks with treatment, including but not limited to muscle strains and sprain, disc injures and strokes, I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intent this consent form to cove r the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____ _____

Name (please print) Signature Date

_____ _____

Witness Date Parent/Guardian (for minors)