VanNess

Chiropractic • Massage • Rehabilitation

Date:_________________

PERSONAL AND FAMILY HEALTH HISTORY

Full Name:____________________________________ I prefer to be called: _________________

Spouse/Guardian:______________________________

Address:____
STREET CITY STATE ZIP

Date of Birth:____/____/____Age:_______Married_______Single_______Widow(er)______

Names of Children		**Under Previous Chiropractic Care**	**Reason / Wellness**
Name:_________________	Age______	Y/N	___________________
Name:_________________	Age______	Y/N	___________________
Name:_________________	Age______	Y/N	___________________
Name:_________________	Age______	Y/N	___________________

Home Tel:(___)____________Work Tel:(___)_____________Cell:(___)___________________

Last 4 of Soc. Sec. # :_________ (Will be your pin for Chirotouch check in) *Children use primary parent

E-Mail Address:_______________________________

Preferred means of appointment reminders:
TEXT / E-MAIL ***if text - cell phone carrier needed:_____________________________

Height:_____ Weight:_____ Most recent blood pressure (if known):______________

Occupation:__________________Employer:_______________________________________

Employer Tel: (___)_________________Full Time ___Part Time___ Pregnant?_________

Emergency Contact:____
NAME PHONE

Spouse's Employer:____
NAME PHONE

Who may we thank for referring you to us:_______________________________________
_____Yellow Pages _____Coupon Magazine ____Insurance Co. _____ Our Family Magazine
_____Internet Referral:___________________ Other:_________________________________

Have you ever been to a chiropractor before?________If yes, __________________________
DR.'S NAME LAST VISIT?

Date of last physical exam:_________By whom:______________Family doctor:__________

Other physicians consulted in past 12 months:____

NAME DIAGNOSIS

Accidents and/or injuries related to current symptoms:

____

ACCIDENT OR INJURY DATE OTHER IMPORTANT INFO. REGARDING INJURY

(IF AN AUTO, WORK OR PERSONAL INJURY, PLEASE REQUEST INSURANCE FORMS FROM FRONT DESK)

Reason for Seeking Care: Please make us aware of all issues of concern today. (i.e. acute conditions, nagging sports injuries, headaches, stress, internal imbalances, arthritis, numbness, etc.)

Primary Complaint:____

____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:______ At its worst: ___**
- **Frequency of discomfort 0%-100%: ________ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? _________ Getting better/worse/no change**
- **Aggravated by:_________________________ Relieved by:__________________________**
- **Discomfort is sharp/achey/tingling/numb/other:__________________________________**
- **Time of day when it is most noticeable:____**
- **Have you ever had this discomfort before (if yes, explain):_________________________**

Secondary Complaint:____

____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:______ At its worst: ___**
- **Frequency of discomfort 0%-100%: ________ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? ______ Getting better/worse/no change**
- **Aggravated by:_______________________ Relieved by:___________________________**
- **Discomfort is sharp/achey/tingling/numb/other:__________________________________**
- **Time of day when it is most noticeable:____**
- **Have you ever had this discomfort before (if yes, explain):_________________________**

Third Complaint:____

____

- **Rate your discomfort 1-10: ____ (10 is worst) At its best 1-10:______ At its worst: ___**
- **Frequency of discomfort 0%-100%: ________ Onset : Gradual / Sudden**
- **How long since you first noticed the discomfort? ______ Getting better/worse/no change**
- **Aggravated by:_______________________ Relieved by:___________________________**
- **Discomfort is sharp/achey/tingling/numb/other:__________________________________**
- **Time of day when it is most noticeable:____**
- **Have you ever had this discomfort before (if yes, explain):_________________________**

Additional information you would like to share with the doctor:

____

____

____

____

Pertinent personal or family history of illness, disease or chronic health conditions?
Mark:(S) for Self (F) for Family

____

____Alcoholism	____Cancer	____Gastric Reflux	____High Cholesterol	____Pacemaker
____Allergies	____Constipation	____Gout	____Irregularity	____Parkinsons Disease
____Anemia	____Degenerative Discs	____Headaches	____Kidney Disease	____Pinched Nerve
____Appendicitis	____Depression	____Heart Disease	____Liver Disease	____Pneumonia
____Arthritis	____Diabetes	____Hepatitis	____Miscarriage	____Prostate Problems
____Asthma	____Emphysema	____Hernia	____Multiple Sclerosis	____Stroke
____Auto Immune	____Epilepsy	____Herpes	____Muscle Spasms	____Thyroid Problems
____Backaches	____Fractures	____Herniated Disc	____Osteoporosis	____Tumors
____Bronchitis	____Gallbladder	____High Blood Pressure	____Other: ______________________	

List all Surgeries:
____

Review of Systems
G-I: ___________________ ENT: ___________________ Bone/Joint: _________________________
Cardiovascular: __________________ Skin: ___________________ Male/Female: _______________

List all medications, nutritional supplements and/or weight loss products you are presently taking (include frequency and dosage):____
____

Alcohol: □ Daily □ Weekly □ Occasional □ Never
Smoking: □ Daily □ Weekly □ Occasional □ Never
Caffeine: □ Daily □ Weekly □ Occasional □ Never
Exercise: □ Daily □ Weekly □ Occasional □ Never
Pain Meds: □ Daily □ Weekly □ Occasional □ Never
Diet: □ Good □ Fair □ Poor
Sleep: □ Back □ Side □ Stomach □ Firm mattress □ Soft mattress □ Other:____________________
Allergies (Food / Seasonal / Meds / Latex): ____
Breast Implants? □Yes □No

Health Insurance Carrier:____

Our goal at Van Ness Chiropractic is to provide complete care for you, your spouse and your children. Please make us aware of any injuries, birth trauma, growth and developmental concerns or recurrent childhood conditions regarding your spouse or children.

____
____
____

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE EVENT COLLECTION EFFORTS BECOME NECESSARY, I AGREE TO PAY ALL COLLECTION COSTS, UP TO 40% REASONABLE ATTORNEY FEES, AND COURT COSTS. I ALSO AGREE TO PAY INTEREST AFTER 30 DAYS AT 5% MONTHLY ON ANY UNPAID AMOUNTS.

SIGNATURE OF PATIENT OR GUARDIAN____________________________________

In special circumstances, other arrangements will be made to accommodate your health care needs regardless of your ability to pay. Simply talk to the doctor.