

### PATIENT INFORMATION *all fields required*

Print Full Name: \_\_\_\_\_ Name you go by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Email: \_\_\_\_\_  
 Marital Status: Married  Single  Spouse's Name: \_\_\_\_\_ # of Children \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 May we contact you at work? Yes  No   
 Most of our patients are referred to our office by a caring family member or friend. How did you hear about our office or who referred you? \_\_\_\_\_

### PHONE NUMBERS

Home: \_\_\_\_\_ Work: \_\_\_\_\_ ext. \_\_\_\_\_ Cell: \_\_\_\_\_  
 Preferred phone number: Home  Work  Cell  Best time to reach you: \_\_\_\_\_  
 In case of emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### HEALTH HISTORY

Chiropractic care is for optimal health and healing. However, most of our patients first seek our help when in a health crisis. What health concerns or crisis brought you to our office?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Is this due to an accident or injury?  Yes  No Type of Accident: Auto  Home  Other: \_\_\_\_\_

Is your condition getting worse?  Yes  No Has your condition been treated in the past by a doctor?  Yes  No

- Spinal misalignments can put pressure on nerves for long periods of time. How long have you had the above problems? (If accident or injury, write date) \_\_\_\_\_
- Nerve pressure & Irritation can be constant or occasional. How often do you have the above problems?  
 It is constant OR  On and off during the day OR  It comes and goes throughout the week
- Irritation to different nerve fibers can create different sensations. Is yours:  sharp  dull  throbbing  
 burning  numb  achy  tingling  radiating?
- Rate your current pain intensity from 0 to 10 with 10 being the worst pain: 0 1 2 3 4 5 6 7 8 9 10
- Spinal misalignments can cause weakening of the entire spine. Is yours worse in the morning, evening, or after a specific activity? \_\_\_\_\_
- What makes your condition better? \_\_\_\_\_
- Poor posture leads to poor health, and often indicates spinal problems.  
 How would you rate your posture:  Poor  Good  Excellent
- Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days: \_\_\_\_\_
- Do you smoke?  Yes  No If yes, how long? \_\_\_\_\_ Do you sleep on your stomach?  Yes  No  Sometimes
- What medications or drugs are you currently taking? \_\_\_\_\_
- Many people with spinal problems experience health crisis before seeking chiropractic care. Have you had any major hospitalizations or surgeries that the doctor should know about? Yes  No  If YES, please explain: \_\_\_\_\_

### ACTIVITIES OF DAILY LIVING

Are you currently experiencing pain or difficulty with performing the following: *Personal care, lifting, reading, concentrating, working, driving, sleeping, recreation, walking, sitting, standing, or social activities?*

List Restricted Activity:  
example: walking

Current Activity Level:  
30 mins. with pain

Usual Activity Level:  
2 hours without pain

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PAST HISTORY

Have you ever been diagnosed with any of the following conditions? Please check  all that apply:

- Broken bone  Dislocations  Tumors  Rheumatoid Arthritis  Fracture  Disability  Cancer  Allergies  
 Heart Attack  Osteoarthritis  Diabetes  Cerebral Vascular  Asthma  Fatigue  Digestive Problems  
 Sciatica  Genetic Disease  Other \_\_\_\_\_

## WORK & FAMILY HISTORY

Work related injuries can cause serious spinal problems. What is your occupation? \_\_\_\_\_

Any past or present health problems or diagnosis in another family member(s)? Yes  No

If YES, please explain: \_\_\_\_\_

## CHIROPRACTIC HISTORY

Research shows that your spine should be checked regularly. When did you last see a chiropractor? \_\_\_\_\_

Reason for care: \_\_\_\_\_ Favorable outcomes? Yes / No Did you follow recommendations? Yes / No

Who else in your family is under chiropractic care? \_\_\_\_\_

## FEMALES ONLY

Spinal health is especially important during pregnancy. Is there any chance you are pregnant? Yes  No

If YES, due date: \_\_\_\_\_ If NO, are you on Birth Control Pills? Yes  No

## HEALTH COMMITMENT

At Vertical Chiropractic, we are dedicated toward achieving the goal of total lasting healing for all of our patients.

To better understand your individual health objectives, please check  all that apply:

Symptom Relief/Temporary Relief  Restore Health  Total Correction  Prevention  Maximum Performance

In addition to the main reason for your visit today, what additional health goals do you have?  
\_\_\_\_\_

## ACKNOWLEDGMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

\_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

\_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

\_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_

\_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, text messages, or health information to me as an extension of my care in this office.

\_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

**Please place an "X" on the diagram to the right where you have any pain, numbness, tingling, or other problems.**

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Doctor Signature Date

