New Patient | Adult

PATIENT INFORMATION

Legal Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

(Street) (City) (Postal Code)

Cell: _____ Home Ph. #: _____ Email: _____

Occupation:_____ Employer:_____

Marital status: __ Single __Married __Divorced __Widowed

Spouse's Name:_____ Spouse's Occupation:_____

# of Children: _____ Names and Ages: _____

How did you hear about us?_____

Have you ever consulted a Doctor of Chiropractic? __Y __N Who?_____ When?_____

MAIN HEALTH CONCERNS

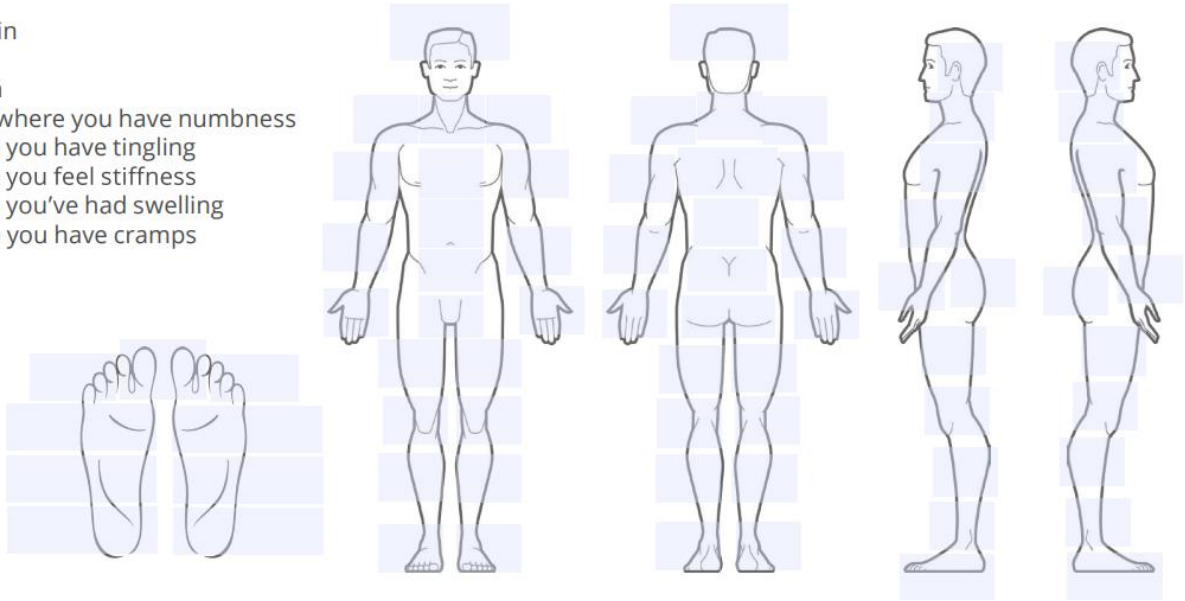
Please list, in order of importance, your chief concerns:

1. _____ 2. _____

3. _____ 4. _____

Please label any areas where you are experiencing the following symptoms:

"//"	stabbing pain
"B"	for burning pain
"D"	for dull pain
"A"	for aching pain
"N"	on or in areas where you have numbness
"T"	in areas where you have tingling
"St"	in areas where you feel stiffness
"Sw"	in areas where you've had swelling
"C"	In areas where you have cramps
"W"	for weakness
"Tr"	for tremor



PERSONAL HEALTH HISTORY

Please list hospitalizations, surgeries, major illnesses and/or medical procedures and the year they occurred.

Please list any major accidents or injuries and the year they occurred.

Do you have now or have ever suffered from:

__Headaches
__Sinus pain/Congestion
__Dizziness
__Balance/Coordination Decline
__Speech Changes
__Heart Disease
__High Blood Pressure
__Heart Palpitations or Arrhythmia
__Cancer
__Stroke
__Anemia
__Poor Circulation
__Cold/Tingling/Numbness in Hands or Feet
__Muscle Aches or Arthritis
__Neuritis
__Skin Irritations
__Acne
__Thyroid Dysfunction
__Hormone Dysfunction
__PCOS
__Painful Breasts
__Frequent UTIs
__Menstrual Pain/Difficulty
__Kidney Stones
__Asthma
__Allergies
__Frequent Colds/URIs
__Diabetes
__Digestive Difficulty
__Heartburn
__Reflux
__Adrenal Dysfunction
__Difficulty Sleeping
__Low Energy
__Tire Easily
__Cognitive Challenges
__Concentration Challenges
__ Memory Decline
__Hyperactivity
__Restlessness
__Anxiety
__Brain Fog
__Depression
__Mood Swings
__Irritability
__Frequent Cravings

Have you ever suffered from an autoimmune condition? __Y __N Which one(s)_____

Please list all prescription and over-the-counter medications you are currently taking and for what symptom:

1. _____ (Name) _____ (Symptom)
2. _____ (Name) _____ (Symptom)
3. _____ (Name) _____ (Symptom)
4. _____ (Name) _____ (Symptom)
5. _____ (Name) _____ (Symptom)
6. _____ (Name) _____ (Symptom)
7. _____ (Name) _____ (Symptom)
8. _____ (Name) _____ (Symptom)
9. _____ (Name) _____ (Symptom)
10. _____ (Name) _____ (Symptom)

Please list any sources of emotional stress that are currently affecting your daily life.

DIET AND LIFESTYLE

Please describe your current diet.

Are you currently taking any nutritional supplements? Please list them.

List any real or suspected allergies/sensitivities to drugs, food, or environmental sources.

Do you use tobacco? __Y __N Number of caffeinated beverages per day ___

Number of alcoholic beverages per week ___ How often do you work out each week?____

On a scale of 1-10, rate the stress level of your typical week ____

Do you have a regular spiritual practice or religious affiliation? If so, then please describe.

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3

Category III

Intolerance to smells Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

Category IV

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting proteins and meats; undigested food found in stools	0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use of antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category VI

Difficulty digesting roughage and fiber	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0 1 2 3
Frequent loss of appetite	0 1 2 3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0 1 2 3
Abdominal distention after certain probiotic or natural supplements	0 1 2 3
Decreased gastrointestinal motility, constipation	0 1 2 3
Increased gastrointestinal motility, diarrhea	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Suspicion of nutritional malabsorption	0 1 2 3
Frequent use of antacid medication	0 1 2 3

Category VIII

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	*YES NO*

Category IX

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

Category X

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful between meals	0 1 2 3
Blurred vision	0 1 2 3

Category XI

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category XII
Cannot stay asleep 0 1 2 3
Crave salt 0 1 2 3
Slow starter in the morning 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3
Headaches with exertion or stress 0 1 2 3
Weak nails 0 1 2 3

Category XIII
Cannot fall asleep 0 1 2 3
Perspire easily 0 1 2 3
Under a high amount of stress 0 1 2 3
Weight gain when under stress 0 1 2 3
Wake up tired even after 6 or more hours of sleep 0 1 2 3
Excessive perspiration or perspiration with little or no activity 0 1 2 3

Category XIV
Edema and swelling in ankles and wrists 0 1 2 3
Muscle cramping 0 1 2 3
Poor muscle endurance 0 1 2 3
Frequent urination 0 1 2 3
Frequent thirst 0 1 2 3
Crave salt 0 1 2 3
Abnormal sweating from minimal activity 0 1 2 3
Alteration in bowel regularity 0 1 2 3
Inability to hold breath for long periods 0 1 2 3
Shallow, rapid breathing 0 1 2 3

Category XV
Tired/sluggish 0 1 2 3
Feel cold—hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increase in weight even with low-calorie diet 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression/lack of motivation 0 1 2 3
Morning headaches that wear off as the day progresses 0 1 2 3
Outer third of eyebrow thins 0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss 0 1 2 3
Dryness of skin and/or scalp 0 1 2 3
Mental sluggishness 0 1 2 3

Category XVI
Heart palpitations 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervous and emotional Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XVII (Males Only)
Urination difficulty or dribbling 0 1 2 3
Frequent urination 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel emptying 0 1 2 3
Leg twitching at night 0 1 2 3

Category XVIII (Males Only)
Decreased libido 0 1 2 3
Decreased number of spontaneous morning erections 0 1 2 3
Decreased fullness of erections 0 1 2 3
Difficulty maintaining morning erections 0 1 2 3
Spells of mental fatigue Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decreased physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips 0 1 2 3
Sweating attacks 0 1 2 3
More emotional than in the past 0 1 2 3

Category XIX (Menstruating Females Only)
Perimenopausal 0 1 2 3
Alternating menstrual cycle lengths 0 1 2 3
Extended menstrual cycle (greater than 32 days) 0 1 2 3
Shortened menstrual cycle (less than 24 days) 0 1 2 3
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3

Category XX (Menopausal Females Only)
How many years have you been menopausal? _____ *Years*
Since menopause, do you ever have uterine bleeding? *YES NO*
Hot flashes 0 1 2 3
Mental fogginess 0 1 2 3
Disinterest in sex 0 1 2 3
Mood swings 0 1 2 3
Depression 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breasts 0 1 2 3
Facial hair growth 0 1 2 3
Acne 0 1 2 3
Increased vaginal pain, dryness, or itching 0 1 2 3

Name_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered.

_____ _____

Signature *Date*

Privacy Act:

I consent to the use of my protected health information by Van Family Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations. HIPAA Compliance.

_____ _____

Signature *Date*

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

***Adjustment**: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.*

***Health**: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.*

***Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____ have read and fully understand the above statements.

(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____

Signature *Date*

For Parent/Guardian of a Minor 18 Years or Younger - Consent to Evaluate and Adjust

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature *Date*

For All Female Patients of Child-Bearing Capability - Pregnancy Release

This is to certify that to the best of my knowledge I am NOT pregnant and Van Family Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

Signature *Date*

Date of last menstrual cycle: _____