Welcome to the

Vinton Chiropractic Center

Please Print — About You

Today's Date: ____/____/____ File #:_____

Name:_____ Age:_____ Birthdate:____/____/____

First: Middle Initial Last

What do you prefer to be called?_____☐Male ☐Female Social Security #_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-Mail Address:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed Spouse's Name:_____

Number of Children:_____ How did you find out about us?_____

Employer:_____ Occupation:_____

Parent's Name (if minor):_____

Emergency Contact:_____ Phone:_____

Where can this office leave messages?_____

Reason For Visit

What brought you here today? (Describe your pain and its location.)_____

_____

When did symptoms first occur?_____

Explain what happened._____

_____

_____

Does this interfere with your normal living and work? ☐ Yes ☐ No In what way?_____

_____

Have you had similar symptoms or injuries before? ☐ Yes ☐ No Explain:_____

_____

List any other doctors seen for this problem:_____

Past History

Has a physician treated you for any health condition in the last year? ☐Yes ☐No If yes, explain:____

_____

Have you received chiropractic treatment before today? ☐Yes ☐No If yes, where, when & what for?

_____

Do you wear: ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐Arch supports

What is the age of your mattress?_____ Is it comfortable? ☐Yes ☐No

For Women: Are you taking Birth Control? ☐Yes ☐No Are you pregnant? ☐No ☐Yes/How long?_____

Are you nursing? ☐Yes ☐No History of menstrual problems? ☐Yes ☐No

History of miscarriage? ☐ Yes☐No

Vinton Chiropractic Center

Name:_____ **File#:**_____ **Insurance ID#:**_____

Health Questionnaire

ALLERGIES TO ANY MEDICATIONS

Please list any medication you are allergic to:_____

_____

ALLERGIES-*Please circle any that apply*

Animals	Aspirin/Pain Medicine	Bee Stings	Chocolates/Sweets	Dairy (milk/cheese)
Dust	Eggs	Latex	Molds	Ragweed/Pollen
Rubber	Seasonal Allergies	Shellfish	Soaps	Wheat
X Ray Dye	Peanuts	None	Others:	

SURGERIES-*Please circle any that apply & provide dates*

Appendix	Back	Brain/Tumor	Carpal Tunnel	Disc	EENT	Elbow
Foot	Gall Bladder	Gastrointestinal	Gynecological	Heart	Hernia	Hip
Jaw	Knee	Neck	Neurological	None	Obstetrical	Other
Shoulder	Tonsils	Wrist/Hand				

Other:_____

MEDICAL HISTORY-*Please circle for yourself, mark "F" for a family member*

Ankle Pain	Arthritis	Asthma	Broken Bones
Cancer	Chest Pain	Depression/Other Mental	Diabetes
Difficulty Breathing	Dizziness	Elbow Pain	Epilepsy
Eye/Vision Problems	Fainting	Fatigue	Foot Pain
Genetic Spinal Disorder	Hand Pain	Headaches	Hearing Problems
Hepatitis	High Blood Pressure	Hip Pain	Jaw Pain
Joint Stiffness	Kidney/Urinary Problems	Knee Pain	Leg Pain
Low Back Pain	Menstrual problems	Mid Back Pain	Multiple Sclerosis
Neck Pain	Neurological Disorder	Pacemaker	Parkinson's Disease
Polio	Prostate Problems	Shoulder Pain	Significant Weight Change
Sinus Problems	Spinal Cord Injury	Stomach Problems	Stroke/Heart Attack
Tumor	Ulcer(s)	Wrist Pain	

Other:_____

LIST MEDICATION & REASON FOR MEDICATION: *(Prescription & Over the Counter)*

PREFERRED LANGUAGE:_____ RACE & ETHINICITY:_____

DO YOU SMOKE? ☐ YES ☐ NO

INSURANCE INFORMATION:

Please have card(s) available for office staff to make a photocopy.

Primary Insured's Name:_____ Birthdate:____/____/____ Relationship:_____

Is this visit related to an auto accident or worker's compensation? ☐ Auto Accident ☐ Worker's Compensation

RESPONSIBLE PARTY:

Person ultimately responsible for account.

Name: Relationship to patient:

Billing address: City: State: Zip:

Primary Phone:

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and unders
my responsibility to inform this office of any changes in my health status.

PATIENT SIGNATURE: **DATE:**_____/_____/_____

(Parent or Guardian, if patient is a minor)

OFFICE USE

Information taken by:_____ Date: _____/_____/_____