VERTICAL
CHIROPRACTIC

ADULT CONFIDENTIAL HEALTH INFORMATION

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 you 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. _____	_____	_____

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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?

_____

ACKNOWLEGMENTS

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.

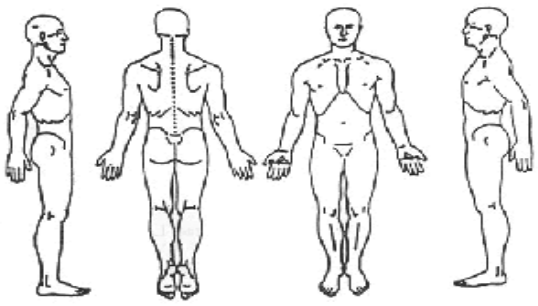
_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

_____ 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