Vital Chiropractic Center

Patient Name: ____ Age:__________
(Last) (First) (MI)
Address:____
(City) (State) (Zip)
Home Ph. (______)______-_______ Work Ph (_____)_______-_______ ext______ Cell:_______________
Email:________________________
Sex: M F DOB____/____/____ SSN _____-_____-______ Status: M S W D Number of children_______
Occupation: ____________________________ Employer: ____________________________________
Spouse's Name:___________________ Whom should we thank for referring you?_____________________

Please complete the following with as much information as possible.

What is your major complaint: ____
How long have you had this condition?______________ Have you had similar problems in the past? Y N
What activities aggravate your condition? ____
What relieves it?____
Is it worse/ better in the AM/ PM? Is it constant: Y N How long does it last:________________________
Does the pain radiate: ____________________________________ Where to: ___________________________
Do you have any other complaints?____
____
____
What do you like to do that your condition(s) prevent you from doing? ________________________________
____

Is the condition interfering with: Work Sleep Daily Routine
Is it progressively getting worse:______________________ How long since you felt well?________________
Is this condition due to an auto accident? Y N If yes please fill out the auto accident form.
Is this condition due to a work injury? Y N If yes please fill out the work injury form.

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
Doctor's Name: ______________________________ Diagnosis: ________________________________
Were x-rays taken: Y N Treatment: ____________ Medication: _______________________________
Physical therapy: _____________________________ Results: __________________________________
Length of time under care: ____________________ Were you off work: Y N
Have you had any surgeries? Y N If yes, list:____
Are you taking any medication? Y N If yes, list:____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Chiropractor will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to the Chiropractor and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional service rendered me will be immediately due and payable.

Patients Signature: ____ **Date:**__________________

Guardian or Spouse's Signature: ____________________________ **Date:**__________________