VITAL LINK CHIROPRACTIC

Patient Initial Health History

FILE #_____ DATE ___/___/___

Name_____**SS#**_____

Street _____**City** _____**State**____ **Zip** _____

Date of Birth: ___/___/___ **Age**: ____ **Sex:** □ M □ F **Marital Status**: □ M □ S □ W □ D

#1 Phone ( ) _____ **#2 Phone** ( ) _____ **Email**_____

Race: □ Amer Indian/Alaskan native □ Asian □ African Amer □ Native Hawaiian/other Pacific island
□ White □ Mixed 2 or more races □ Choose not to identify

Ethnicity: □ Hispanic/Latin □ non-Hispanic/Latino □ Choose not to identify

Employer: _____ **Occupation/Job Title:**_____

Family Physician: _____**Emergency Contact Info:** _____

How specifically were you referred to Vital Link? _____

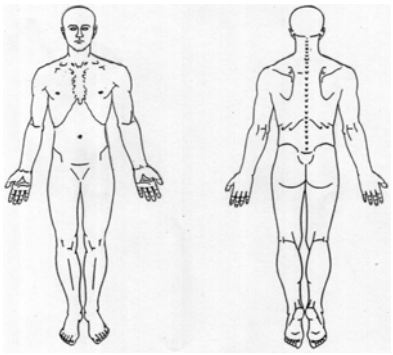
Insurance Information (Please check type)

Highmark ____ 1st Priority ____ Aetna ____ Geisinger ____ Medicare ____ Other _____
Work Injury _____ Auto/Personal Injury _____ Other _____
Primary Insured: Self _____ Spouse ____ Other _____
If other than Self: Insured's Name _____ D.O.B. _____Employer _____

Please list the main reasons you are seeking our help:

1. _____. How Long Have You Had This? _____
2. _____. How Long Have You Had This? _____
3. _____. How Long Have You Had This? _____

****Please mark an X on the picture (right) where you have pain / symptoms:**



How often are your symptoms present?
□ 0 – 25% □ 26 – 50% □ 51 – 75% □ 76 – 100%

How do you feel this occurred? _____

Please rate your pain over the last week: mild ..1 2 3 4 5 6 7 8 9 10 …severe

What specific activities of your daily routine does your condition interfere with? _____
_____

Describe your symptoms:

□ Dull □ Achy □ Sharp □ Throbbing □ Stabbing □ Shooting □ Burning □ Tingling □ Numbness
Do your symptoms radiate into your □ arms □ legs? _____

What worsens the symptoms?

□ Sitting □ Standing □ Walking □ Bending □ Lifting □ Exercise □ Coughing/Sneezing □ Straining
□ Turning L or R □ Looking up/down □ Sleeping □ Other _____

What relieves the symptoms?

□ Sitting □ Standing □ Walking □ Bending □ Ice □ Heat □ Exercising □ Resting □ Advil/Tylenol
□ Pain Meds □ Hot/Cold □ Biofreeze/Mineral Ice □ Massage □ Other _____

Other Doctors seen for this condition: □ Chiropractor □ Medical Dr. □ Other

1. Name/Address: _____
Date: _____What was the diagnosis? _____
What was done? _____
2. Name/Address: _____
Date: _____What was the diagnosis? _____
What was done? _____

Health History: **Please check all of the following that apply to you:**

NO	YES	Condition	NO	YES	Condition
□	□	History of recent infection	□	□	Prostate Problems
□	□	Recent fever	□	□	Frequent urination
□	□	HIV/AIDS	□	□	Pregnancy, # of births _____
□	□	Diabetes	□	□	Recent bodyweight □ Gain □ Loss
□	□	Corticosteroid use (oral/injection)	□	□	Epilepsy/ Seizures
□	□	Birth control pills	□	□	Visual Disturbances / Frequent headaches
□	□	High blood pressure	□	□	History of Low/Mid back pain
□	□	Previous stroke (Date) _____	□	□	History of neck pain
□	□	Dizziness/ Fainting	□	□	Arthritis (inflammatory types)
□	□	Numbness in Groin/ Buttocks	□	□	Alcohol use _____
□	□	Loss of bowel or bladder control	□	□	Smoking/Tobacco use _____ years
□	□	Aortic Aneurysm	□	□	Asthma
□	□	Cancer/ Tumor	□	□	Broken Bones_____
□	□	Osteoporosis	□	□	Previous surgery _____
□	□	Recent Trauma	□	□	Currently taking medication: (list below)
□	□	Medication Allergies: (list below)			

Family History:

□ Cancer □ Diabetes □ High blood pressure □ Cardiovascular Disease/Stroke □ Thyroid □ Back Problems
□ Scoliosis □ Inflammatory arthritis □ Auto-immune disease □ Other: _____
Do You Have a Pacemaker? □ Yes □ No Could You Be Pregnant? □ Yes □ No
Do you take any blood thinners? □ Yes □ No How many hours of sleep per night?_____

Have you ever:

Belonged to a health club? □ Yes □ No
Consumed vitamins or supplements? □ Yes □ No
Encountered difficulty with dietary changes or adjustments? □ Yes □ No

If you require:

Dietary changes (weight loss) or nutrients would you like to be informed? □ Yes □ No
Specific exercises would you like to be informed? □ Yes □ No
Support in the psychological/mind/body/stress dimension of health would you like to be informed? □ Yes □ No

Records Release

Vital Link Chiropractic Offices is authorized to obtain, examine & make copies of medical records, x-rays and reports pertaining to your treatment of my condition. This authorization is valid until revoked in writing by me. A photocopy of this authorization and my signature has same effect as the original.

Patient Signature _____ Date ____/____/____

Office Use Only:

Height _____ Weight _____ Pulse _____ Resp _____ B/P _____/_____mmHg