Vert. Fitness & Wellness Center **PATIENT INTAKE**

Patient Information

Today's Date: SSN: Birthday: Email:
First Name: Middle Name: Last Name: Preferred:
Gender: M F Nonbinary Other: please specify if you like Height: Weight:
Partner or Spouse's Name (if applies):
# of Children (if applies):
Home #: Cell #: Work #:
Mailing Address: City: State: Zip:
Emergency Contact Name: Emergency Relation: Emergency Phone:

Referral Information

Referring Physician:
Referring Friend or Family Member:
Referring Advertisement (Walk In/Google/Yelp/Health Talk/Facebook/Other):

Employer Information

Current Position (if applies):
Employer Name:
Employer City: Employer State: Employer Zip:
Work Duties Include:

Payment Information

Payment Type (please circle): Time of Service Health Insurance
(PLEASE PROVIDE COPY OF YOUR HEALTH INSURANCE CARD)

Patient Lifestyle

Alcohol:	Daily	Weekly	Occasion	Never
Caffeine including energy drinks:	Daily	Weekly	Occasion	Never
Non prescription or street drugs:	Daily	Weekly	Occasion	Never
Homemade food:	Daily	Weekly	Occasion	Never
Processed or packaged foods:	Daily	Weekly	Occasion	Never
Soft drinks:	Daily	Weekly	Occasion	Never
Tobacco or second hand tobacco:	Daily	Weekly	Occasion	Never
Water:	Daily	Weekly	Occasion	Never

Patient Health History

Last Physical Exam: Primary Physician: Physician Phone #:
Physician City: Physician State:
Previous Chiro Care: Yes No Date: Explain:
Pregnant? Due Date: Planning to get pregnant: Yes No
Medications & Supplements:
Broken Bones: Yes No Explain: All Surgeries (birth to current):
Sprains/Strains: Yes No Explain:
Hospitalized: Yes No Explain:
Past Auto Accident: Yes No Explain:

For OFFICE USE ONLY:
Reviewed by: Notes

Vert. Fitness & Wellness Center **PATIENT INTAKE**

Current or Past Health Checklist (circle what applied/s to you)

Allergies	Alcoholism	Anemia	Arteriosclerosis	Arthritis
Asthma	Back Pain	Breast Lump	Bloating	Bronchitis
Bruise Easily	Cancer	Chest Pain	Cold Extremities	Constipation
Cramps	Concussion	Seizure	Autoimmunity	Heart Dx
Vascular Dx	Depression	Diabetes	Digestion Problems	Dizziness
Eating Disorder	Menstruation Issues	Eye Pain or Difficulties	Fatigue	Frequent Urination
Headache	Hemorrhoids	High Blood Pressure	Hot Flashes	Irregular Heart Beat
Kidney Infection	Kidney Stones	Loss of Memory	Loss of Balance common new	Loss of Smell
Loss of Taste	Loss of Hearing	Nausea	Faint	Pain worse at Night loss of sleep
Abdominal Swelling	Abdominal Pain	Migraine within last 6 months	Diarrhea	Insomnia
Nosebleeds	Pacemaker	Polio	Poor Posture	Prostate Trouble
Sciatica	Shortness of Breath	Sinuses	Stroke	Spinal Curvatures
Swelling of Ankles	Swollen Joints	Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Excessive Weight Gain	Excessive Weight Loss	Strep
Flu	Pneumonia	Epilepsy	Blood Sugar high or low	

Other:

Tell us why are you here

Describe your primary discomfort?

How often do you feel the discomfort: Always Hourly Daily Occasionally

Does it interfere w/ activities: Yes No

Affects sleep: Yes No

Missed work: Yes No Unable to Work from: Unable to Work til:

Affects appetite: Yes No Explain:

Weather affects it: Yes No Explain:

What else aggravates condition:

What improves condition:

Received any other treatment (i.e. massage, acupuncture, ortho): Yes No Explain:

X-rays taken: Yes No Explain:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic. I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest. If any doctor(s) in this business prescribe needed x-rays with patient denial the business has right to refer patient to another doctor. I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Patient Signature: Date:

For OFFICE USE ONLY:

Reviewed by: Notes