Valley Wellness & Chiropractic, Inc.

Welcome! Please fill out these information pages so we may better serve you.

(present insurance information and identification to office staff)

PLEASE PRINT CLEARLY. **TODAY'S DATE: _____**

Full Name: _____ Sex: _____ Age: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____
Phone: (home) _____ (work) _____ (cell) _____
Employer: _____ Duties: _____
Social Security #: _____ Work Status: __ full time, __ part time, __ retired
Email address: _____ May we email you: YES____ NO____
Spouse, Parent, or Guardian: _____ Age: _____ Birth Date: _____ SS#: _____
Their employer: _____ Their Phone: (cell) _____ (work) _____
In Case of Emergency Contact: _____ Relationship: _____
Phone: (cell) _____ (home) _____ (work) _____
How did you hear about our practice or who may we thank for referring you? _____
Type of payment; Cash__, Credit Card__, Your auto insurance__, Health Insurance__, Medicare__, Other_____

Describe Your Current Condition and How It Began:

(place a check mark for only one condition here – if more than one condition then fill out rest on the next page)

Headache_____ Neck_____ Shoulder/Arm/Elbow/Hand_____ Mid-Back_____ Low-Back_____ Leg/Knee/Foot_____
Ear Infections___, Chiropractic Wellness Care_____, Other – describe _____

When did condition Start: _____ **Is condition getting;** worse____, better____, or staying the same___

How did condition start: _____

Did the condition begin: Gradually___, Sudden___, or Progress over time___

How often do you experience your condition?
Intermittently (0-25% of day) _____, Occasionally (26-50%) _____, Frequently (51-75%) _____, Constant (76-100%) _____

What makes worse? Bending__, lifting__, twisting__, sitting___, standing___, walking___, running___, laying___, coughing___, sneezing___, driving___, riding___, pushing___, pulling___, watching TV___, reading___, housework/work___, other_____

What causes relief? Nothing__, rest__, exercise__, bracing__, sitting__, standing__, laying __, heat__, cold__, other_____

Does this condition interfere with your; work___, sleep___, social life___, home duties___, recreation___, other_____

Does the pain radiate into; shoulder__, arms__, elbow__, fingers__, buttocks__, hips__, legs__, knee__, feet__, toes__

Type of pain; sharp__, dull__, ache__, burn__, throb__, numb__, tingling__, other_____

Feels worse in; morning___, afternoon___, evening___, middle of night___, after activities____

HOW DOES THIS CONDITION FEEL TODAY? (circle a number that best describes)

0 1 2 3 4 5 6 7 8 9 10
No pain **Unbearable**

Who have you seen about this and dates? _____
When and what treatments have you received? _____
The results of previous treatments were; not effective____, poor____, good____, very effective____, other_____
What test have been performed and when? X-rays_____, MRI_____, CAT scan_____, other_____
Have you had similar problems in the past? When and what? _____
What treatments might have you received for similar problem in past? _____
Previous Chiropractic? _____ **When?** _____ **Why?** _____ **Results**_____
In what position do you sleep? Back__, Side__, Stomach__ **How many hours of sleep do you get?** _____
Do you sleep with a pillow? Yes__, No__ **How many and what type?** _____

(ANY OTHER CONDITIONS YOU WANT US TO KNOW ABOUT?)

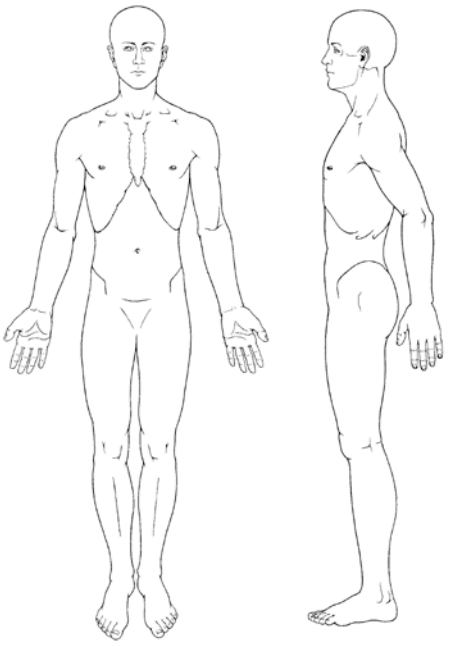
Headache_____ Neck_____ Shoulder/Arm/Elbow/Hand_____ Mid-Back_____ Low-Back_____ Leg/Knee/Foot_____
Other – describe _____
When did condition start: _____ **Is condition getting worse**____, better____, or staying the same____
How did condition start: _____
Did the condition begin: Gradually___, Sudden___, or Progress over time___?
How often do you experience your condition?
Intermittently (0-25% of day) _____, Occasionally (26-50%) _____, Frequently (51-75%) _____, Constant (76-100%) _____
What makes worse? Bending__, lifting__, twisting__, sitting___, standing___, walking___, running___, laying___, coughing___, sneezing___, driving___, riding___, pushing___, pulling___, watching TV___, reading___, housework/work___, other_____
What causes relief? Nothing__, rest__, exercise__, bracing__, sitting__, standing__, laying __, heat__, cold__, other_____
Does this condition interfere with your; work___, sleep___, social life___, home duties___, recreation___, other_____
Does the pain radiate into; shoulder__, arms__, elbow__, fingers__, buttocks__, hips__, legs__, knee__, feet__, toes__
Type of pain; sharp__, dull__, ache__, burn__, throb__, numb__, tingling__, other_____
Feels worse in; morning___, afternoon___, evening___, middle of night___, after activities____

HOW DOES THIS CONDITION FEEL TODAY? (circle a number that best describes)

0	1	2	3	4	5	6	7	8	9	10
No pain										Unbearable pain

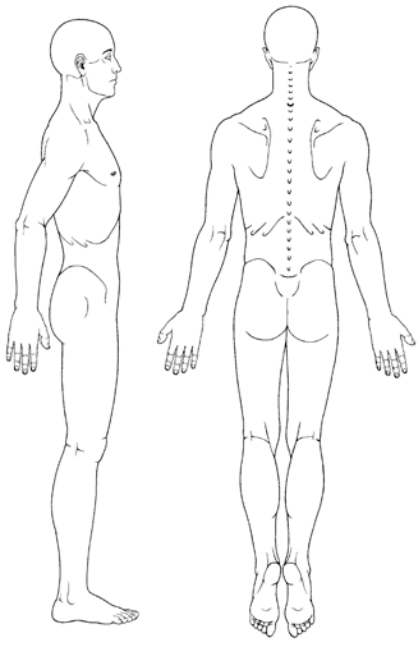
Who have you seen about this and dates? _____
When and what treatments have you received? _____
The results of previous treatments were; not effective____, poor____, good____, very effective____, other_____
What test have been performed and when? X-rays_____, MRI_____, CAT scan_____, other_____
Have you had similar problems in the past? When and what? _____
What treatments might have you received for similar problem in past? _____

PAIN LOCATION



Please circle the area on the diagram that indicates where your condition(s) is. Then mark on the diagram by using the letters below to indicate what type of condition(s) you are experiencing.

X = PAIN, DISCOMFORT
N = NUMBNESS
T = TINGLING
B = BURNING



Other Symptoms past or present: (Check all that apply)

Many patients are surprised to find out that chiropractic and/or wellness care may help many of the below conditions, feel free to ask how your condition may also be affecting the above complaints.

□ Dizziness/ Vertigo
□ Backaches
□ Earaches
□ Diabetes
□ Breathing
□ Colds/Flu
□ Migraines
□ Arthritis
□ Insomnia
□ Joint Pain
□ Cancer
□ Osteoporosis
□ Heart Problems
□ Bone fractures
□ Anemia
□ Poor Appetite
□ Hyperactivity/ Behavioral
□ Fainting
□ Urinary problems
□ Bed Wetting
□ Convulsions
□ Loss of smell
□ Muscle jerking
□ Walking problems
□ Epilepsy
□ Broken bones
□ Ruptures
□ Hernias
□ Neck Problems
□ Arm problems
□ Leg problems
□ Growing pains
□ Blood disorders
□ Stomach aches
□ Irritability
□ Sore throats
□ Depression
□ Loss of balance
□ Bronchitis
□ Coordination
□ Muscle Cramps
□ Acid Reflux.

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of yours.

Car accidents 5+ ___ 3-4 ___ 1-2 ____ Please describe any injuries or treatment:

_____

_____

Which of the following sports have you been involved in?

□ Football
□ Basketball
□ Gymnastics
□ Horseback
□ Soccer
□ Baseball
□ Cheerleading
□ Martial Arts

Other:_____

Have you or do you?

□ Fallen down the stairs
□ Slipped/Fell on the ground
□ Sports injury
□ Stress or strain while working
□ Broken a bone if so, which one(s)? _____ _____
□ Sit more than 4 hours per day
□ Drive more than 2 hours per day
□ Perform repetitive tasks (typing/lifting/etc.) what are they?___ _____ _____ _____

□ Exercise: □ 1-3x wk □ 4-7x wk. □ None. Member of a health club or gym? □ Yes □ No.

Circle all prescription and non-prescription medicines you are taking:

□ Asthma
□ Tylenol
□ Advil/Ibuprofen
□ Cold/Allergy
□ Blood Pressure
□ Muscle Relaxors
□ Anti-Depressant
□ Anxiety
□ Sleep Aids
□ Blood Thinners
□ Hormones
□ Attention Aids
Other:
_____
_____
_____
_____
_____

Do you take any Vitamins or Herbs? □ Yes □ No _____