VITAL LINK
CHIROPRACTIC

FILE #_____ **Patient Initial Health History** DATE ___/___/___

Name_____**SS#**_____

Apt#/Street _____**City** _____**State**____ **Zip** _____

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

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

Appointment Confirmation Reminders by: □ text □ email

(Please do NOT reply to email or text. Call the office to cancel or reschedule)

Race: □ Asian □ African American □ Hispanic □ White □ other

Your Employer _____ **Occupation/Job Title**_____

Insurance Information (Please check type)

□ Work Injury □ Auto/Personal Injury □ Private □ Self Pay

Primary Insured: □ Self _____ □ Spouse ____ □ Other

If other than Self: Insured's Name _____ D.O.B. _____Employer _____

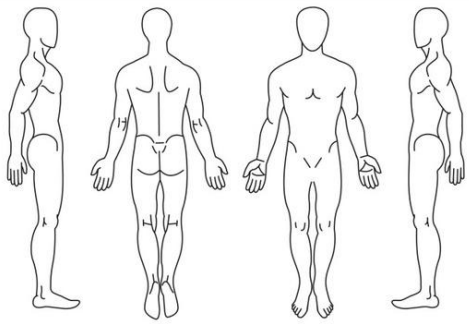
Family Physician _____ Emergency Contact Info: _____

How specifically were you referred to Vital Link?_____

Last Visit to a Chiropractor? _____Month ____Year ____ □ Never

Please list the main reasons you are seeking our help:

1. _____ Pain Level (1-10) _____
2. _____ Pain Level (1-10) _____
3. _____ Pain Level (1-10) _____



****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%

Do you know the causation of your complaints? _____

_____

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

_____

Symptom Description: Where do you feel these sensations? _____

□ 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?: _____
Diagnostic Tests or Treatment performed?_____
Are you open to recommendations in dietary changes, supplementation, and/or home exercises? Yes No

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

NO	YES	Condition	NO	YES	Condition
□	□	History of recent infection	□	□	Frequent urination
□	□	Recent fever	□	□	Pregnancy, # of births _____
□	□	HIV/AIDS	□	□	Recent bodyweight □ Gain □ Loss
□	□	Diabetes	□	□	Epilepsy/ Seizures
□	□	Corticosteroid use (oral/injection)	□	□	Visual Disturbances / Frequent headaches
□	□	Birth control pills	□	□	History of Low/Mid back pain
□	□	High blood pressure	□	□	History of neck pain
□	□	Previous stroke (Date) _____	□	□	Arthritis (inflammatory types)
□	□	Dizziness/ Fainting	□	□	Alcohol use _____
□	□	Numbness in Groin/ Buttocks	□	□	Asthma
□	□	Loss of bowel or bladder control	□	□	Broken Bones_____
□	□	Aortic Aneurysm	□	□	Previous surgery _____
□	□	Cancer/ Tumor	□	□	Smoking/Tobacco use: _____ years
□	□	Osteoporosis			□ current □ former □ never
□	□	Recent Trauma	□		Currently taking medication: (list below or attach)
□	□	Prostate Problems			
□	□	Medication Allergies: (list here or attach) >			

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?_____

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