



Welcome To Vitruvian Wellness Center

First Name _____ MI _____ Last _____ Birth Date ____ / ____ / ____ Age _____
 Email Address _____ Home Phone No. _____ Cell Phone No. _____
 Employer: _____ Occupation _____
 Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*
 Have you ever been to a chiropractor before? Y / N When was your last adjustment _____

Your Health Profile

***FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please "Circle" if necessary to be more specific)

_____ Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both		_____ Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L Both	
_____ Headaches/Migraines	_____ Hip Pain R / L	_____ Neck Stiffness/ Pain	_____ Back Stiffness/Pain
_____ Fractured Bones	_____ Arthritis	_____ Frequent Colds / Flu	_____ Diabetes
_____ Swollen Painful Joints	_____ Convulsions/Epilepsy	_____ Skin Problems	_____ Cancer
_____ Anemia	_____ Tremors	_____ Blurred Vision R / L	_____ Double Vision R / L
_____ Pain w/ Cough / Sneeze	_____ Chest Pain	_____ Lung Problems	_____ Loss of Taste
_____ Heart Problems	_____ Stroke	_____ Gall Bladder Problems	_____ Digestive Problems
_____ Prostate Problems	_____ Kidney Trouble	_____ Loss of Smell	_____ Loss of Balance
_____ Dizziness/Vertigo	_____ Buzzing/Ringing in ears	_____ Sinus Problems/Allergies	_____ Nervousness/Anxiety
_____ Fatigue	_____ Depression	_____ Irritability/Mood Swings	_____ Tension/Stress
_____ Colon Trouble	_____ Sleeping Problems	_____ Cold Hands	_____ Stomach Upset
_____ Cold feet	_____ Bed Wetting	_____ Recurring Infection	_____ Diarrhea/Constip./Gas
_____ Foot Problems	_____ Shortness of Breath	_____ Hot Flashes	_____ Jaw/TMJ Problems
_____ Cold Sweats	_____ Light Bothers Eyes	_____ Problems Urinating	_____ Heartburn/Reflux
_____ High Blood pressure	_____ PMS	_____ Menopause	_____ Ulcers
_____ Cancer (Type) _____	_____ Other _____		

Additional Explanation: _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No

Was this due to an accident/Trauma? Yes No

If Yes, explain. (ex. fall, auto, sports) _____

Symptoms: When this problem is at its worst, can you explain in your words how exactly it feels? _____

Severity: Mild Moderate Severe

Does this pain travel or radiate? If so, Where? _____

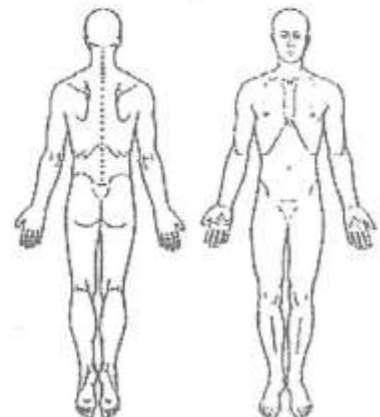
Quality: (mark all that apply)

Burning Diffuse Dull/Aching Localized

Sharp Shooting Stabbing Tingling Radiating Other _____

Is there anything that makes this better or worse? _____

Please mark on the diagram below, the areas of your discomfort



Timing of Symptoms:

- Worse Am Worse Pm Worse with activity Worse Sleeping
- Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

How often do you find yourself suffering from this problem? _____

How long does the problem last? (All the details of timing) _____

What solutions have you attempted to solve this problem? _____

DAILY ACTIVITIES: EFFECTS OF CURRENT CONDITION ON PERFORMANCE

- | | | | | |
|------------------------|------------------------------------|---|---|--|
| Carrying Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Changing Positions | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Sit to Stand | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Climbing Stairs | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Pet Care | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Driving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Extended Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Household Chores | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Lifting Children | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Reading/ Concentration | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Self-Care – Bathing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Self-Care – Dressing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Self-Care – Shaving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Sexual Activities | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Sleep | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Sitting Still | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Standing Still | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Yard Work | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| Walking | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |

Please list any effects that this may have on any recreational activities: _____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Your Primary Dr.: _____ Phone Number: _____

Have you seen your Doctor or anyone else for this/these conditions? No Yes

Doctor's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Diagnosis by your Doctor: _____

Lab work completed, if any: _____

CURRENT MEDICATIONS/SUPPLEMENTS OR OVER THE COUNTER ITEMS CURRENTLY BEING USED.

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

How many of the following do you consume on a daily basis?

Coffee (Cups) _____ Tea (Cups) _____ Alcohol (Drinks) _____ Water (Cups) _____ Cigarettes _____

Have you had any significant accidents, injuries or illnesses?

Hospitalizations or surgeries you have had, and your age at the time:

Are you pregnant N Y – How far along? _____ Do you have a pacemaker/defibrillator? _____

Is there anything else you think the doctor should know concerning your condition? No Yes _____

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, it is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infinity

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation we encounter non-chiropractic or unusual finding we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

Signature: _____ Date: _____



Name: _____

Date _____

Rate your level of pain with the Pain Scale (VAS):

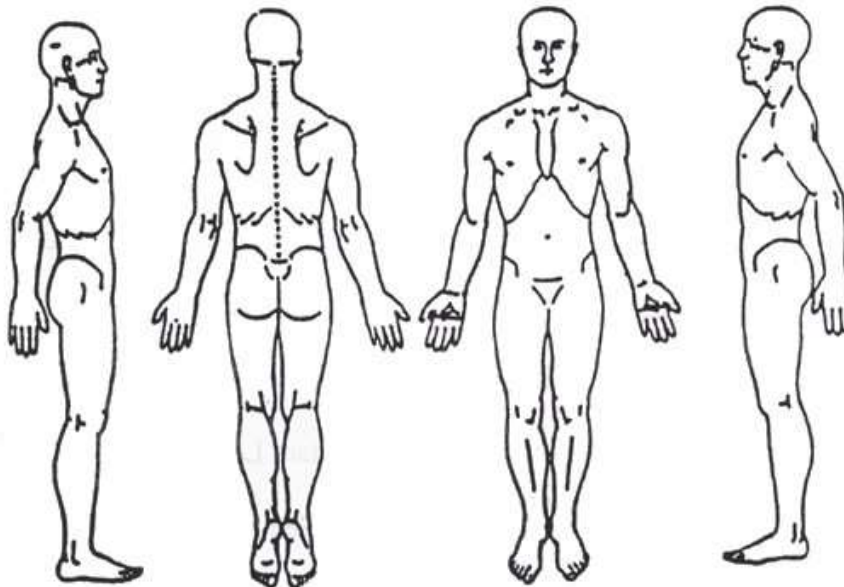
Rate your pain level by marking the appropriate box that best describes your level of pain on a scale of 0 – 10.

	No Pain	1	2	3	4	5	6	7	8	9	10 Intense Pain
What is your pain right now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is your typical or average pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is your pain at its worst?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Show us where you hurt using this Pain Diagram:

Please DRAW us what your PAIN is by SHADING IT IN ON THE BODY DIAGRAM below.
Be as accurate as you can, and do NOT use "X"s and arrows.

Use the following descriptors of your pain and show where they are on the body diagram
A: Achy N: Numb S: Sharp T: Tight SB: Stabbing P: Pins and Needles



PATIENT INFORMATION
PLEASE COMPLETE ALL LINES. PRINT ALL INFORMATION.

Last Name	First Name	MI	
Street Address	City	State	Zip Code
Home Phone No.	Work Phone No.	Cell Phone No.	
Date of Birth	Social Security No.	Sex	Marital Status
Employer	Occupation	Student	
Employer's Address	City	State	Zip Code
Nearest Relative	Address	Phone No.	

Billing Responsibility (Send Bills To)

Last Name	First Name	MI	
Street Address	City	State	Zip Code
Employer	Occupation	Student	
Employer's Address	City	State	Zip Code

Insurance Information

Insurance Company Name	Insurance ID No. – Claim No.		
Subscriber – Insured Party	Date of Birth	Social Security No.	Relationship
Other Insurance Company Name	Insurance ID No. – Claim No.		
Subscriber – Insured Party	Date of Birth	Social Security No.	Relationship
Referring Physician	Address of Referring Physician		
Date of Accident	Accident Location (Auto, Home, Work, Etc.)		



IT IS OUR OFFICE POLICY TO CHARGE **35.00** FOR ALL APPOINTMENTS NOT CANCELLED OR RESCHEDULED PRIOR TO **24** HOURS OF YOUR SCHEDULED APPOINTMENT TIME. THIS FEE IS YOUR RESPONSIBILITY AND WILL BE BILLED DIRECTLY TO YOU.

SIGNATURE _____ DATE _____

PATIENT ACKNOWLEDGEMENT

*For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations*

_____ (Print name) _____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request, The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided at the front desk. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand

(Signature of Patient/ Guardian)

(Date)

(Patient/Guardian's name printed)