VITRUVIAN
Wellness Center

Welcome to Vitruvian Wellness Center

Date: _____ **Patient #: _____** **Doctor: _____**

Name: _____Birth Date: _____Cell phone:_____
Address: _____City: _____State: _____Zip: _____
Email address: _____Marital status: M S W D Number of children?_____
Sex: Male__ Female__ Other__ Weight:_____ Height:_____ Ethnicity: Hispanic/Latino __Not Hispanic/Latino __Unknown__
Race: American Indian/Alaska Native__ Asian__ Black/African American__ Native Hawaiian/Pacific Islander__ White__ Other____
Occupation: _____Employer: _____
Employers address: _____Office phone: _____
Spouse: _____Occupation: _____Employer: _____
Emergency Contact: _____Phone#: _____
How were you referred to our office? _____
Family Medical Doctor: _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ___Yes ___No

HISTORY OF PRESENT ILLNESS

Chief Complaint / Purpose of this appointment: _____
Date symptoms appeared or accident happened: _____
Is this due to: Auto ____Work ____Other _____
Have you ever had the same or a similar condition? ___Yes ___No If yes, when and describe: _____
_____
Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions? (Check all that apply)

__Broken Bones	__Osteoarthritis	__Eating Disorder
__Circulatory problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pacemaker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer (type)_____	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High Blood Pressure	__ Insulin Dependent Diabetes	__Non-Insulin Dependent Diabetes
__Low Blood Pressure	__Coughing Blood	__Ulcers (type)_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____
Have you been treated for any health condition by a physician in the last year? __Yes __No
If yes, describe: _____
What medications or drugs are you taking? _____
Do you have any allergies to any medications? __Yes __No
If yes, describe: _____
Do you have allergies of any kind? __Yes __No
If yes, describe: _____
Please list any other health problems you have, no matter how insignificant they may be: _____
_____

SOCIAL HISTORY

Do you drink alcoholic beverages? __Yes __No If so, how much per week? _____
Do you use any tobacco products? __Yes __No Do you smoke? __Yes __No If so, how much? _____
Do you take vitamin supplements? __Yes __No If so, please list: _____
Do you consume caffeine? __Yes __No If so, how much per day? _____
Do you exercise? __Yes __No If so, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day do you spend with __lifting, __sitting, __bending, __working at a computer (at home or at your job away from home): _____%

FAMILY HISTORY

Father: __living __deceased (check one) Current age if still living: ____
Cause of death and age at death if deceased: _____
Mother: __living __deceased (check one) Current age if still living: ____
Cause of death and age at death if deceased: _____
Check if applicable to you: __As an adopted child, little is known of birth parents or family.

FAMILY DISEASES (check if applicable and indicate whether **M**aternal/**P**aternal side or **S**ister/**B**rother):

__Tuberculosis	__Cancer (type)_____	__Mental Illness
__Diabetes insulin dependent	__Diabetes non-insulin dependent	__Asthma
__Heart Disease	__Stroke	__Kidney Disease
__Lung Disease	__Arthritis	__Liver Disease
__Other		

Please check any and all insurance coverage that may be applicable in this case:

__Major Medical	__Medicaid	__Medicare	__Auto Accident
__HSA & FSA	__Other		

Name of Primary Insurance Company: _____
(if this is a motor vehicle accident, this is the insurance company of the vehicle you were in)
ID or Claim Number:_____ Policy number: _____
Subscriber`s Name: _____ Relationship to Patient: _____
Address: _____ Birth Date: _____
(if different than Patient)

Name of Secondary Insurance Company (if any): _____
ID Number:_____
Subscriber`s Name: _____ Relationship to Patient: _____
Address: _____ Birth Date: _____
(if different than Patient)

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors to secure the payment of benefits. I further authorize the release of my medical records to this office. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%. We reserve the right to charge a $50.00 fee for appointments missed without 24-hours notice.

The patient understands and agrees to allow this chiropractic office to use Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning the privacy of your Patient Health Information. We encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient`s Signature: _____ Date: _____
Guardian`s Signature Authorizing Care: _____ Date: _____

What is your major symptom? _____
What does this prevent you from doing or enjoying? _____
If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? __Yes __No __Same __Better __Gradually worse
If yes, when and how? _____
How frequent is the condition? __Constant __Daily __Intermittent __Night only
Are there any other conditions or symptoms that may be related to your major symptom? __Yes __No
If yes, describe: _____
Describe the pain: __Sharp __Dull __Numbness __Tingling __Aching __Burning __Stabbing __Other
Is there anything you can do to relieve the problem? __Yes __No If yes, describe: _____
_____ If no, what have you tried to do that has not helped? _____
What makes the problem worse? __Standing __Sitting __Lying __Bending __Lifting __Twisting __Other
WOMEN ONLY: Are you pregnant, or is there any possibility you may be pregnant? __Yes __No __Uncertain
Remarks: _____

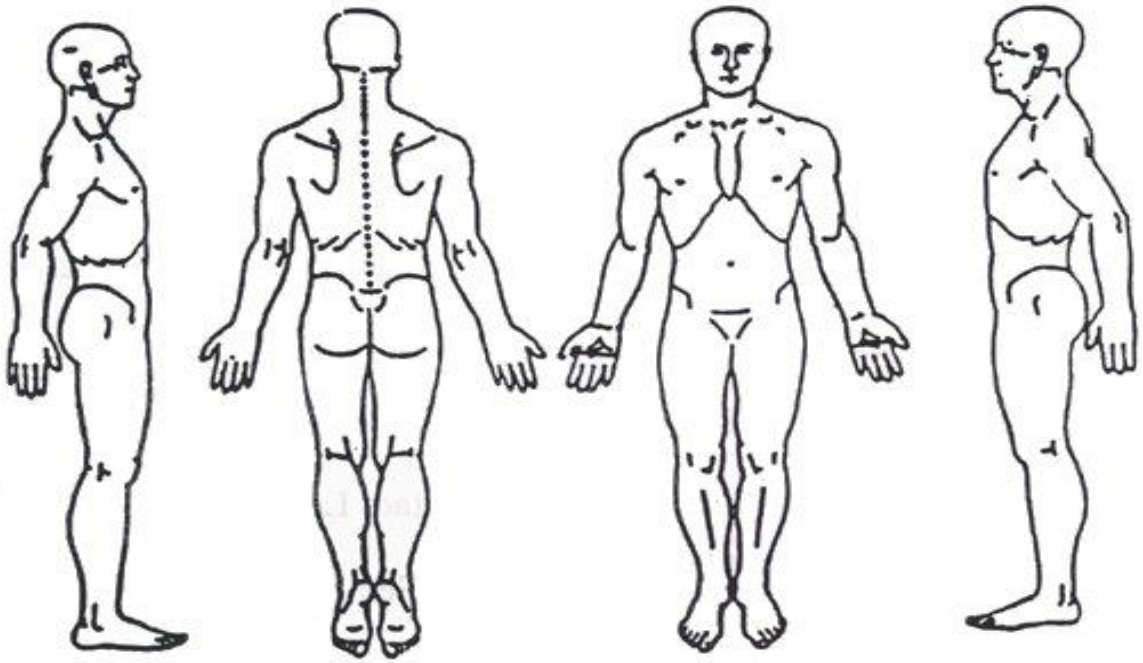
Please place an "X" on the line above to indicate level of problem

No Symptoms — Extreme Symptoms

1 2 3 4 5 6 7 8 9 10

Tell Us Where You Hurt

Mark an "X" on the picture where you continue to have pain, numbness or tingling.



Patient`s Signature: _____ Date: _____
Guardian`s Signature Authorizing Care: _____ Date: _____