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: _____

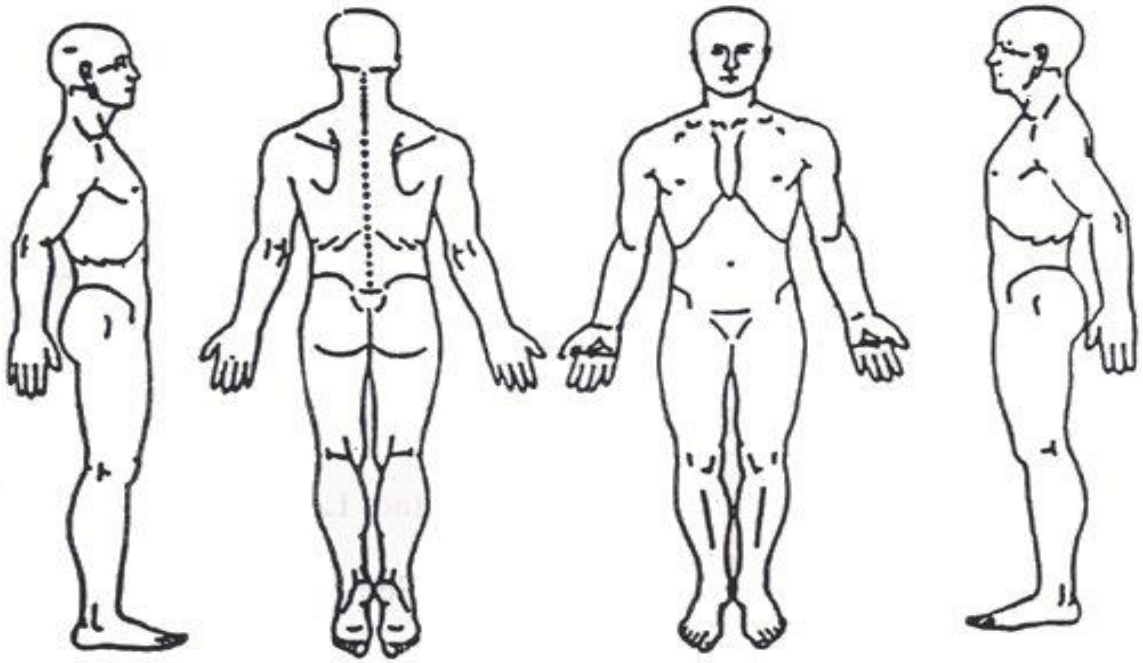
Please place an "X" on the line above to indicate level of problem

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: _____

ALLERGY INTAKE FORM

Name: _____ Phone Number: _____ DOB: ___/___/_____

Provider's Name: _____ Date of Visit: ___/___/_____

CIRCLE ALL THAT APPLY:

Do you suffer from allergies? YES NO

If **yes**, which seasons: SPRING SUMMER FALL WINTER ALL YEAR

If **yes**, which of the following symptoms do you typically have:

-SNEEZING -ITCHY AND/OR WATERY EYES -SCRATCHY THROAT -CONGESTION -CHRONIC COUGH

-FATIGUE -RESTLESSNESS -POST NASAL DRIP -JOINT PAIN -ITCHY DRY SKIN -HIVES -RUNNY NOSE

OTHER: _____

How long have you had these symptoms?_____years__months

When do you typically experience them the most: Morning Afternoon Night All Day

YES NO Do you frequently get sinus infections, colds, flu or a runny nose?

YES NO Have you been diagnosed with Asthma? If **yes**, is it controlled? YES NO

YES NO Do you take any antihistamine medications to control these symptoms? If yes, please list them below & date last taken:

Please list **ALL** medications you are currently on, and the date last taken:

_____

_____

YES NO Are you Pregnant? If **no**, are you planning on becoming pregnant within the next year? YES NO

YES NO Are you HIV positive or have AIDS?

YES NO Are you taking any Beta Blocker Medications? If **yes**, which one: _____

YES NO Are you taking any Antibiotic Medications? If **yes**, which one: _____

YES NO Do you have any Auto Immune Diseases? If **yes**, which one: _____

YES NO Have you been Allergy Tested in the last 12 months? If **yes**, are you on immunotherapy? YES NO

YES NO Are you planning on relocating within the next 12 months?

YES NO Have you ever had a life-threatening allergic reaction and need emergency medical attention?

YES NO Do you have Dermagraphism?

YES NO Do you have any known food allergies? If **yes**, which one: _____

Patient Signature:_____ Date: ___/___/____

Allergy Tech Name: _____ Allergy Tech Signature: _____

Allergy Diagnosis- (OFFICE USE ONLY)

Patient Name: _____ DOB: ___/___/____ DOS: ___/___/____

Code: _____ BP: ___/___ Pulse: ___bpm Peak Flow:____

Diagnosis

Nose and Sinus	
J30.0	Vasomotor
Upper Respiratory	
J45.20	Mild intermittent asthma, Uncomplicated
J45.30	Mild persistent asthma, Uncomplicated
J45.40	Moderate persistent asthma, Uncomplicated
J45.50	Severe persistent asthma, Uncomplicated
Allergies	
J30.1	Rhinitis due to pollen (Hay Fever)
J30.2	Other seasonal allergic rhinitis
J30.5	Rhinitis due to food
J30.81	Rhinitis due to animal hair and dander
J30.89	Other allergic rhinitis
Eye	
H10.45	Other chronic allergic conjunctivitis
H10.411	Chronic giant papillary conjunctivitis, Right Eye
H10.412	Chronic giant papillary conjunctivitis, Left Eye
H10.413	Chronic giant papillary conjunctivitis, Bilateral

Patient previously seen, treated, or complained about listed symptoms: YES NO
Referred for Allergy Testing: YES NO
Provider Notes:

_____

_____

Medications to remain off (if any): _____

Provider Signature: _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score