

# Welcome to Van Til Chiropractic

## 1 About You

### FOR OFFICE USE

Patient Number: \_\_\_\_\_  
NP \_\_\_\_\_

Coverage: PI WC MM MC SP  
\_\_\_\_\_

Tests performed:  
Infrared Thermography  
Postural Analysis  
Orthopedic Tests

X-Rays: \_\_\_\_\_  
Cervical  
Thoracic  
Lumbar

Other: \_\_\_\_\_

Promo: \_\_\_\_\_

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: ☐ Male ☐ Female

Name: \_\_\_\_\_

What do you prefer to be called: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

City State Zip

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ (Friend / Family / Co-Worker)

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Type of work performed? \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical Physician's Name: \_\_\_\_\_

## 2 Reason for Your Visit

Have you had previous chiropractic care? ☐ Yes ☐ No

If so, how long since your last visit? \_\_\_\_\_

Is this a wellness check? ☐ Yes ☐ No If yes, please skip to back side

What is your chief complaint? \_\_\_\_\_

How did the condition develop? \_\_\_\_\_

When did it start? \_\_\_\_\_

What offers relief? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

How would you describe discomfort?

☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Stabbing

What percentage of the time does this condition bother you?

☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How would you rate the level of discomfort on a scale of 0-10?

(0=No Pain 10=Extreme Pain) \_\_\_\_\_

Have you had similar problems in the past? ☐ Yes ☐ No When? \_\_\_\_\_

Is this condition getting worse? ☐ Yes ☐ No ☐ Comes and Goes

Other complaints? \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

# 3 Your Health History

Are you currently taking any vitamins or supplements? ☐ No ☐ Yes If yes, please list \_\_\_\_\_

Are you currently taking any medication? Please check ALL of the boxes that apply or allow the front desk to copy any lists.

☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners  
☐ Tranquilizers ☐ Insulin ☐ Other(s) \_\_\_\_\_

Have you ever had any of the following diseases/medical conditions?

<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Bones/Joints
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No Lower Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No Colitis
<input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol/Drug Abuse

Please list any allergies you may have: \_\_\_\_\_

List any and all accidents with dates: \_\_\_\_\_

List all previous surgeries/treatments with dates: \_\_\_\_\_

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

Do you exercise regularly? ☐ No ☐ Yes / How often? \_\_\_\_\_

Do you smoke? ☐ No ☐ Yes / How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing shoe inserts? ☐ No ☐ Yes

## For Women:

Are you taking birth control? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes / How far along? \_\_\_\_\_

Are you nursing? ☐ No ☐ Yes

# 4 Read and Sign

- We invite you to discuss with us any questions regarding our services and office policies. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy is to sit down and discuss all financial arrangements with each patient on a case by case basis. Your payments will be made in our office when possible and we will bill your insurance if appropriate for their responsibility.
- For past due accounts that owe \$250 or more, you will be required to pay at least \$50.00 each visit before being seen.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_