VENN CHIROPRACTIC
& WELLNESS CENTER

Date: _____ File #:_____

Name: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

DOB: _____/_____/_____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Spouse's Name: _____

Cell Phone Carrier: AT&T Verizon T-Mobile Sprint Other _____

Circle One: Opt **IN** or **OUT** for text message appointment reminders
via the cell phone number you provided

In Case of Emergency:

Physician: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How did you find out about our office? And whom may we thank for referring you to us?

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Terms of Acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only three goals: to LOCATE, ANALYZE, and CORRECT spinal interference within the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (Spinal misalignment producing nerve interference) in and of itself, does NOT allow the body to function at its optimal level. Chiropractic allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health.

We do not diagnose condition(s) or disease(s) other than vertebral subluxations.
We offer no treatment of these condition(s) or disease(s) other than vertebral subluxations.
We promise no cure from any condition(s) or disease(s).

I _____, having read the above statement, and understanding it fully, do undertake Gonstead Chiropractic health care on these bases.

Date: _____ Signature: _____

- I understand that I am personally responsible for all fees and charges. I understand that payment is due at the time services are rendered. I understand that any third party payer may choose not to reimburse me for the cost of any health care procedure. I understand that if my third party payer chooses not to reimburse me for any reason, including but not limited to a deductible not being met, I am personally responsible for all fees and charges. I understand that a $25 charge will be applied to all returned checks. I understand that any reconciliation or adaptation of fees are at the discretion of the Chiropractor and is to be kept confidential between the chiropractor and myself. I agree to receive important information regarding my chiropractic care via email, phone or mail. By signing I understand and agree to the above financial agreement.

Print Name: _____

Signature: _____ Date: _____

If patient is a minor:

I authorize the doctors at Venn Chiropractic & Wellness Center to care for my child. I have read and understand the term of acceptance and agree to them.

Patient or Legal Guardian: _____

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Consultation History

If information is unavailable-please write N/A

What is your main complaint?

Date when symptom first appeared: _____

BELOW, Please CIRCLE the option that best answers the following questions:

Origination?	Gradual	Sudden	Overtime
Severity?	Mild	Moderate	Severe
Frequency?	Constant	Frequent	Occasional
Problem Side?	Left	Right	Bilateral (both)

Pain Intensity (1-10), 10 being the worst: _____

Explain your type of pain: (ex: aching, burning, sharp, shooting, throbbing, tingling)

What caused this illness/pain: _____

What relieves symptoms: _____

What makes the problem worse: _____

My pain is worse in the: MORNING AFTERNOON EVENING NIGHT (circle one)

Numbness or Tingling? Circle: YES NO
If yes, please explain where: _____

Does the pain radiate? Circle: YES NO
If yes, please explain where: _____

Any other complaints? _____

FOR WOMEN: ARE YOU CURRENTLY PREGNANT? (CIRCLE ONE) YES NO

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Medical History

FAMILY

(Check each box that applies)

	How many?	Back?	Heart?	Stroke?	Cancer?	Diabetes?	High BP?	Good Health?
Mother:	———							
Father:	———							
Sisters:								
Brothers:								
Children:								

SOCIAL

(Check each box that applies)

	Daily	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Standing:							
Sit at a desk:							
Work on a Computer:							
Work on the phone:							
Moderate/ Heavy labor:							
Stay at home:							
Deliver packages:							
Retired:							
Tobacco/ Smoke:							
Alcoholic beverages:							
Caffeine:							
Exercise:							

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SURGICAL

Surgery(s) Performed:	Date of Performance:

ALLERGIES

Description:	Date Detected:

CURRENT MEDICATIONS

Medication:	Reason for use:

PRE-EXISTING CONDITIONS LIST

(Please circle all that apply)

Addiction	Colitis	Heart Disease/Attacks	Paralysis
Anemia	Constipation	Heart Murmur	Pneumonia
Arrhythmia	Depression/Anxiety	Hemorrhoids	Polio
Arthritis	Diabetes	Hepatitis	Prostate Problems
Asthma	Dizziness	High/Low Blood Pressure	Reflux/Ulcers
Blood Clots	Eating Disorder	High Cholesterol	Rheumatic Fever
Blurred Vision	Emphysema	HIV/AIDS	Seizures
Blood Disorder	Epilepsy	Joint/Back Pain	Sexual Dysfunction
Bowel Problems	Gall Bladder Disease	Kidney Infection	Sickle Cell
Broken Bones	Genital Herpes	Kidney Disease/Stones	Stroke
Cancer	Glaucoma	Liver Disease	Suicidal Thoughts
Cataracts	Gout	Mental Disorder	Thyroid Disease
Chickenpox	Hearing Loss	Migraines	Tuberculosis
Cold Sores	Headaches	Osteoporosis	Abnormal Urine

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Agreement of Treatment

On every visit after determining what is necessary for your care, a spinal adjustment (98941) and or an extra spinal adjustment (98943) will be given.

In addition, in order to increase joint range of motion and to decrease muscle spasm, you will be required to use the massage chair in the changing rooms for mechanical traction (97012) either before or after the treatment with the doctor.

I _____, understand and agree to receive and participate in the above treatments.

Patient Signature _____ Date: _____

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HIPPA Agreement

<u>Notice the following agreement will be read and signed in office.</u>

I have received and read the notice of privacy practices from Venn Chiropractic and Wellness Center.

Print Name: _____

Signature: _____ Date: _____

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Here at Venn Chiropractic, we aim to accommodate ALL of your wellness needs!

Are you interested in gaining more knowledge about our other services/products we offer?

(Check all that apply)

- ○ **Massage Therapy**
- ○ **Whole Food Supplements**
- ○ **NormaTec Compression Therapy**
- ○ **Hypnotherapy & Life Coaching**
- ○ **Physical Therapy**