PATIENT INFORMATION

Date _____ First Name _____ Middle Name _____ Last Name

_____ SSN _____ Sex _____ Birth Date _____ Height

_____ Weight _____ Marital Status _____ Spouse Name

_____ Number of Children _____ Address

_____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone

_____ Email

_____ Emergency Contact

_____ Emergency Relation _____

Emergency Phone _____

REFERRAL INFORMATION

I was referred by

_____

How did you hear about the clinic?

Advertisement Newspaper Community Event Provider Talk Family/Friend Other _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name _____ Plan Name

_____ Phone # _____ Primary ID/Policy

_____ Primary Group # _____ Policy Holder's Name

_____ Policy Holder's DOB _____ If you are

NOT the Policy Holder, what is your relation to the Policy Holder?

_____ For verification puposes, what is the Policy Holder's Social

Security Number? _____

Secondary Insurance Information

Insurance Company Name _____ Plan Name _____ Phone # _____ Secondary ID/Policy _____ Secondary Group # _____ Policy Holder's Name _____ Policy Holder's DOB _____ If you are NOT the Policy Holder, what is your relation to the Policy Holder? _____ For verification puposes, what is the Policy Holder's Social Security Number? _____

EMPLOYER INFORMATION

Employed? Yes No Employer Name _____

Occupation

_____

REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	June 2007	4 times per week	Mild / Moderate / Severe
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well?

_____ Did something trigger your health changes?

Sleep

Average number of hours you sleep? _____ Do you have trouble falling asleep? Yes No Do you feel rested upon awakening? Yes No Do you have problems with insomnia? Yes No Do you snore? Yes No Do you use sleeping aids? Yes No Explain: _____

Injuries

Describe your injury and pain:

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? _____ At its worst? _____ Now? _____ Type of injury

_____

How did it occur? Work Automobile Fall Other _____ Injury Date _____ Have you missed work related to this injury? Yes No Unable to work from (dates) _____ to _____ Received other treatment for this? Yes No Where or by whom? _____ X-rays taken? Yes No Do you currently receive chiropractic care? Yes No What clinic or chiropractor provides that care?

_____

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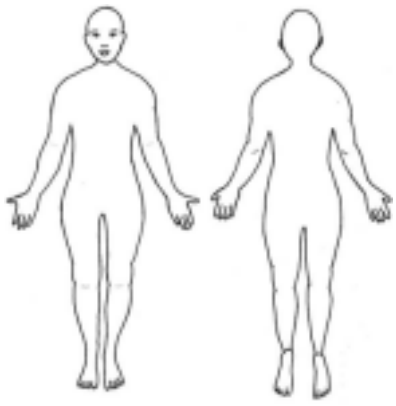

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8IBU BDUJWJUJFT NBLF TZNQUPNT 8034& 4JUUJOH 4UBOEJOH $PVHIJOH 4OFF[JOH

TPbacco/Alcohol

Currently using tobacco? Yes No How many years? _____ Packs per day _____

If yes, what type? Cigarette Smokeless Cigar Pipe Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? Yes No If yes, explain:

_____

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

None 1 to 3 4 to 6 7 to 10 More than 10

Previous alcohol intake? Yes No If yes, was it: Mild Moderate High

Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.	
Medication Name	**Dosage**

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.	
Supplement Name	**Dosage**

Health History

Have you ever had any of the following:

Illnesses A LIST OF ILLNESSES	**Yes**	**No**
Chicken Pox		
Measles		
Mumps		
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High Blood Pressure		
Irritable bowel		

Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Other (describe)		

Injuries A LIST OF ILLNESSES	**Yes**	**No**
Head Injury		
Neck Injury		
Back Injury		
Fracture		
Other (describe)		

Diagnostic Studies	**Yes**	**No**	**Date Performed**
Chest X-ray			
Mammogram			
EKG			
Colonoscopy			
Upper GI Series			
Barium Enema			
CAT scan of abdomen			
CAT scan of brain			
CAT scan of spine			

Liver scan			
Bone scan			
Neck X-rays			
Back X-rays			
MRI			
Bone Density Test			
Blood Tests			
Other (describe)			

Operations A LIST OF ILLNESS	**Yes**	**No**
Tonsillectomy		
Tubes in Ears		
Appendectomy		
Gall Bladder		
Hernia		
Hysterectomy		
Dental Surgery		
Other (describe)		

Hospitalizations A LIST OF ILLNESSES

When	**For What Reason**

Women Specific

Check the box if yes and provide number.

Pregnancies _____ Miscarriage _____ Living Children _____ Abortion _____ Cesarean _____ Vaginal Delivery _____ Postpartum Depression _____ Toxemia _____ Baby Over 8 Pounds _____ Gestational

Diabetes _____

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length

_____ Painful? Yes No Clotting? Yes No Have you ever missed your period? Yes

No For how long? _____ Are you menopausal? Yes No Age At Menopause _____ Last

Menstrual Period _____

Do you take any hormone contraception? Birth Control Pill Patch Nuva Ring

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Varga Family Chiropractic – A Wellness Way Affiliate. I authorize Varga Family Chiropractic – A Wellness Way Affiliate and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize Varga Family Chiropractic – A Wellness Way Affiliate to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature fore required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/ accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 72-business-hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By clicking the submit button below, I agree to the financial policy described above and will adhere to all of its practices. **Please email this completed form to richmond@thewellnessway.com.**

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