

# Vital Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ Zip code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: M S W D How many children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Social Security # \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

Who performed it? \_\_\_\_\_ Where \_\_\_\_\_

Have you ever been to a chiropractor? \_\_\_\_\_ What did they do? \_\_\_\_\_

How many times did you go? \_\_\_\_\_ Did you like the care you received? \_\_\_\_\_

How do you grade your physical health?

Excellent \_\_\_ good \_\_\_ bad \_\_\_ getting better \_\_\_ getting worse \_\_\_

How do you grade your emotional/mental health?

Excellent \_\_\_ good \_\_\_ bad \_\_\_ getting better \_\_\_ getting worse \_\_\_

Do you follow any specific nutritional program? \_\_\_\_\_

Are you interested in learning more about healthy eating habits? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

Describe your level of physical activity? high \_\_\_\_\_ medium \_\_\_\_\_ low \_\_\_\_\_

Are you active in any particular sport? \_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_ Do wake up feeling rested? \_\_\_\_\_

How would you rate your current level of stress? HIGH MEDIUM LOW NONE

Is there a specific complaint you have for which you are seeking our help today? \_\_\_\_\_

If yes – Please Describe: \_\_\_\_\_

\_\_\_\_\_  
*(Please feel free to use the back of this page if you need more space)*

How long have these symptoms been present? \_\_\_\_\_

Have you seen any other Doctors for this condition? \_\_\_\_\_

Have you ever experienced this condition before? \_\_\_\_\_ When? \_\_\_\_\_

Have you taken any medication for **this** condition? \_\_\_\_\_

Were they prescribed or over-the-counter? \_\_\_\_\_

How often do you take it? \_\_\_\_\_ Does it help? \_\_\_\_\_

Which activities aggravate your condition? Standing Sitting Walking Bending

Twisting Lifting Coughing Lying

Do you take any other medication? \_\_\_\_\_ Please list the medication, and what you take it for?

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Have You Ever Suffered From:	YES	NO		YES	NO
1. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	9. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	10. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Have you been treated for any health condition by a physician in the last year?  YES  NO

Describe \_\_\_\_\_

Are you allergic to anything that you know of? Food, drug, or environmental? \_\_\_\_\_

Have you ever been in any type of vehicular collision? If yes, please describe \_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Have you ever injured your spine? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Have you had any spinal x-rays, CAT Scans, or MRI's of your spine or head? \_\_\_\_\_

Please check the type of care desired so that we may be guided by your wishes when possible:

Temporary relief       Control of immediate problem       Total healthcare  
 I prefer the Dr. to select the type of care she feels is best for me

#### **PAYMENT IS EXPECTED AT THE TIME OF SERVICE!**

Name of Person Responsible for Payment \_\_\_\_\_

Do you have Medical Insurance?  YES  NO Company \_\_\_\_\_

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Serendipity A Chiropractic Wellness Center will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Serendipity A Chiropractic Wellness Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.*

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

IF YOURS IS AN ACCIDENTAL INJURY  
PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ AM \_\_\_ PM

Location \_\_\_\_\_

How did Accident Occur?  Auto Collision  On-the-Job Injury  Other \_\_\_\_\_

If not an auto collision, please describe the circumstances:

\_\_\_\_\_

Did you report the injury to your foreman or employer  YES  NO

Did he/she recommend care at our office?  YES  NO

If auto accident, were you  Driver  Passenger  Pedestrian

If auto collision, were you struck from:

Behind  Right Side  Left Side  Front  Auto was Parked

Did your car strike the other[s] involved?  YES  NO

OR did the other car strike yours?  YES  NO  UNDETERMINED

As a result of the accident, were traffic citations issued to you?  YES  NO

To the driver of the other car?  YES  NO

To the driver of your car?  YES  NO

List the extent of the injuries as you know them: \_\_\_\_\_

\_\_\_\_\_

Did you require post-accident hospitalization?  YES  NO

Check symptoms you have noticed since accident:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring         | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Smell     | <input type="checkbox"/> _____         |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Depression               | <input type="checkbox"/> Loss of Taste     | <input type="checkbox"/> _____         |

Have you lost any days of work?  YES  NO Dates: \_\_\_\_\_

Insurance Companies involved:

My Company \_\_\_\_\_

Company of person responsible for injuries? \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative regarding this claim?

YES  NO

Do you have an attorney that has advised you in this case?  YES  NO

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

# HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by using the following codes:  
 C – Currently have P – Previously had

## MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

## FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast

Are you pregnant?  
 Yes  No

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult to swallow
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Blood stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

## CARDIO-VASCULAR RESPIRATORY SYSTEM

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problem
- Heart problem
- Lung problems
- Varicose veins

## EYE, EAR, NOSE, AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Difficult breathing Thru Nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

Please mark your areas of pain  
 On the figures below

