Vibrant Energy HealingCenter

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Today's Date: ___________________ **Case #**________________________

Section 1: About You

Name: ____ ____ Male ____ Female

What you prefer to be called: ___________________________ Referred By: ________________________

Birthdate: ________/________/________ Age: _____Email____

Address: ____ Home Phone #: ______________________

____ Cell Phone #: ________________________

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Spouse's Name: ____________________________Children? How many/ages: ________________________

Your Employer: ____

Occupation: ____ How Long? __________________________

Employer Phone #: _________________________ Cell Phone #: ______________________________

Section 2: Reason For Your Visit

Have you ever been treated by a Chiropractic Physician before? ___ Yes ___ No If yes, please explain:

____

The reason for this visit is a result of (please circle one): Work Sports Auto Accident Trauma Chronic

Explain what happened: ____

Please describe your symptoms: ____

When did this condition begin: _____________________ Is this condition getting worse? ___ Yes ___ No
___ Constant ____ Comes and Goes

Have you had this or similar conditions in the past? ___ Yes ___ No Explain: __________________________

Have you been treated by an M.D. for this condition? ___ Yes ___ No Where: __________________________

Did it help? ___ Yes ___ No Any other complaints? ____

List any past accidents with dates: ____

What type of pain(s) or symptom(s) do you have? Sharp Dull Achiness Soreness Burning
Throbbing Tingling Numbness Pins & Needles Other: ______________________

Does the pain travel from one area to another? ___ Yes ___ No

If yes, where? Arm Hand(S) Leg(S) Foot Neck Head Mid-back Low-back
Other__________

This condition is interfering with: Work Sleep Daily Routine Other______________________

What activities aggravate this condition? ______________________

What have you done at home to try to relieve this pain? ________________ Did it help? ___ Yes ___ No

Section 3: Health History

Are you taking any of the following medications?

___ Nerve Pills ___ Pain Killers ___ Muscle Relaxers ___ Antidepressants ___ Anti-inflammatory
___ Stimulants ___ Insulin ___ Blood Thinners ___ Aspirin ___ Birth Control
___ Others: ______________________Supplements______________________

Have you ever had any of the following diseases/medical conditions (circle those which apply)

Y N Rape/ Date Rape
Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N HIV + / AIDS
Y N Emphysema/TB
Y N Rheumatic Fever
Y N Heart Palpitations
Y N Ulcers/Colitis
Y N Insomnia
Y N Lower Back Problems
Y N GI Complaints
Y N Heart Surg./Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles

Y N Abuse Phys/Sex/Emotional
Y N High/Low Blood Pressure
Y N Diabetes/Glaucoma
Y N Panic Attacks
Y N Arthritis
Y N Chronic Fatigue/Fibromyalgia
Y N PMS/Menopausal Symptoms
Y N Artificial Joints
Y N Varicose Veins
Y N Spinal Curvature
Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Difficulty Breathing

Y N Seizures
Y N Asthma/Allergies
Y N Sciatica
Y N Psychiatric Problems
Y N Frequent Neck Pain
Y N Kidney/Bladder Problems
Y N Sinus Infections
Y N Hives
Y N Boils/Skin Rashes
Y N Hay Fever
Y N Ear Discharges/Noises
Y N Headaches
migraine tension
severe frequent

Please list any other medical condition(s) you have ever had:
____

Please list anything (including foods) that you may be allergic to:
____

Do you smoke? ___ No ___ Yes How much? ________________ How long? ________________

Do you drink alcohol? ___ No ___ Yes Amount: ________________ ____________ times per week

Are you pregnant? ___No ___ Yes How long? ________________ Nursing? ___ Yes ___ No

Any broken bones, fractures, dislocations? ___ No ___ Yes Where? ____________ When? ____________

Have you had any surgeries or been hospitalized? ___ Yes ___ No

If yes, please indicate when and reason: ______________________

Date of last physical examination: ______________________________ Results: __________________________

Women: Date of last pap smear/mammogram: ___________________ Results: __________________________

Have you been in an auto accident? ____ No ___ Yes

If yes, please indicate the year and a brief description of the accident: ___________________________________

____

Have you had any other personal injury or accident? ___No ___ Yes

If yes, please indicate the year and a brief description of the accident: ___________________________________

____

Family Health History:

Please indicate whether there is any history of the following conditions in your immediate family and give the details below:

- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Mental Illness
- ☐ Auto-immune Disorders
- ☐ Asthma
- ☐ Allergies
- ☐ Psoriasis
- ☐ Eczema
- ☐ Alcoholism
- ☐ Drug Abuse

Other conditions which may be pertinent to your present state of health (please attach sheet if space is required):

____

To help us better explain chiropractic, acupuncture, and our other treatments and how we may be able to help you, please check the ONE BEST answer for each statement below. All answers are correct, you are simply stating your preference.

I remember important things in my life by: ___ What I see ___ What I hear ___ What I feel

The primary reason I brush my teeth is to: ___ avoid tooth decay/gum disease
___ make sure I have healthy teeth & gums

When I make decisions I generally: ___ gather facts & weigh the evidence ___ make my choice instantly___ consult my friends & family ___ it depends on how I “feel” about it

I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic, Acupuncture, or any other technique necessary to help my condition, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. 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 and treatment, any fees for professional services rendered me will be immediately due and payable. I also state I have answered all information accurately, honestly, and to the best of my knowledge

Patient’s/Guardian’s Signature X ____ Date _______________