Welcome to
Van Til Chiropractic

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: ______________________

1 About You

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?

❑ Yes ❑ No Heart Attack	❑ Yes ❑ No Diabetes	❑ Yes ❑ No Kidney Problems
❑ Yes ❑ No Stroke	❑ Yes ❑ No Fainting	❑ Yes ❑ No Sinus Problems
❑ Yes ❑ No Congenital Heart Defect	❑ Yes ❑ No Seizures	❑ Yes ❑ No Difficulty Breathing
❑ Yes ❑ No Heart Murmur	❑ Yes ❑ No Epilepsy	❑ Yes ❑ No Arthritis
❑ Yes ❑ No Heart Surgery	❑ Yes ❑ No Frequent Neck Pain	❑ Yes ❑ No Artificial Bones/Joints
❑ Yes ❑ No Pacemaker	❑ Yes ❑ No Lower Back Pain	❑ Yes ❑ No Anemia
❑ Yes ❑ No Mitral Valve Prolapse	❑ Yes ❑ No Headaches	❑ Yes ❑ No Ulcers
❑ Yes ❑ No Artificial Valves	❑ Yes ❑ No Shingles	❑ Yes ❑ No Colitis
❑ Yes ❑ No Low Blood Pressure	❑ Yes ❑ No Glaucoma	❑ Yes ❑ No Asthma
❑ Yes ❑ No High Blood Pressure	❑ Yes ❑ No Cancer	❑ Yes ❑ 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. 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.
- 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 ______/ ______/ ______