VIRTUE CHIROPRACTIC HEALTH HISTORY

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____-_____-_____ Age: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: ____-____-_____ E-mail Address: _____ Occupation: _____

Spouse's Name (if applicable) _____ Have you ever been in the Military? ○ Yes ○ No

Whom may we thank for referring you to our office? _____

FEMALES: Are you pregnant? Yes__ No__ Due date___/___/___

Pain and Health Concerns

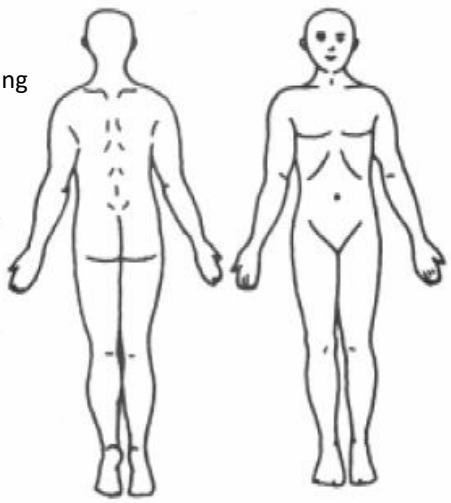
Area of Pain or Health Concern: (List according to severity)	**Rate Severity:**	**When did this problem start?**	**Did the problem begin with an injury?**	**Are symptoms constant (C) or intermittent (I)**
Primary: _____	**0-1-2-3-4-5-6-7-8-9-10**	**___/___/_____**	**YES NO**	**C I**
Second: _____	**0-1-2-3-4-5-6-7-8-9-10**	**___/___/_____**	**YES NO**	**C I**
Third: _____	**0-1-2-3-4-5-6-7-8-9-10**	**___/___/_____**	**YES NO**	**C I**
Fourth: _____	**0-1-2-3-4-5-6-7-8-9-10**	**___/___/_____**	**YES NO**	**C I**

Have these Condition(s) ever been treated by anyone in the past? ○ No ○ Yes

If yes, when? _____ by whom_____

What relieves your symptoms? _____

What makes your symptoms feel worse? Lifting—Bending—Standing--Walking—Sitting—Driving--Laying



PLEASE MARK the areas on the body diagram with the following **LETTERS** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What is your pain level right **now**? 0---1---2---3---4---5---6---7---8---9---10

What is your **average** level of pain? 0---1---2---3---4---5---6---7---8---9---10

What is your pain level at its **best**? 0---1---2---3---4---5---6---7---8---9---10

What is your pain level at its **worst**? 0---1---2---3---4---5---6---7---8---9---10

Please list any injury(s) **and/or** conditions that the doctor should know about:

_____

Please mark: **C** for **Currently** have **P** for in the **Past** **N** for **Never**

___ Headache	___ Chest Pain	___ Dizziness	___ Pregnant (Now)	___ Ulcers
___ Neck Pain	___ Convulsions/Epilepsy	___ Impotence	___ Heartburn	___ Loss of Balance
___ Jaw Pain, TMJ	___ Fainting	___ Digestive Issues	___ Cerebral Vascular	___ Heart Problem
___ Shoulder Pain	___ Tumors	___ Scoliosis	___ High Blood Pressure	___ Trouble Sleeping
___ Upper Back Pain	___ Blurred Vision	___ Diabetes	___ Low Blood Pressure	___ Cancer
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Difficulty Breathing
___ Low Back Pain	___ Foot or Knee Problems	___ Back Curvature	___ Menstrual Problems	___ Broken Bone
___ Hip Pain	___ Swollen/Painful Joints	___ Numb/Tingling arms, hands		___ Numb/Tingling legs, feet
___ Dislocations	___ Rheumatoid Arthritis	___ Heart Attack	___ Other serious condition(s): _____	

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Virtue Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (print)

_____ ____/____/____ ___ *Witness Initials (obtained in office)*
Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____
Patient Name (print)

_____ ____/____/____ ___ *Witness Initials (obtained in office)*
Patient or Authorized Person's Signature Date

Functional Rating Index

Regarding your MAIN COMPLAINT

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities.

For each item below, please select the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on shorts trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25 % of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____

PRINTED

_____ _____

Signature **Date**

VIRTUE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA Policy at the front desk. Please initial to indicate you have been made aware of its availability____.

_____ _____

Patient's Signature Date

Medical Information Release Form (HIPAA Release Form*)*

Release of Information*:*

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

Signed: _____ Date: _____

Witness: _____ Date: _____