New Adult Practice Member History Form

To our new practice members: Welcome to Vital Force Chiropractic! To help us establish you with our practice, please provide us with your health history. If you have any questions, please let us know. We look forward to working with you to achieve your health goals.

First Name Middle Last Nickname

Birthdate Age Gender [M F] Marital Status[S M W D P]Spouse/SO name

Address City/State Zip

Best Phone [mobile work home] Other Phone [mobile work home]

Mobile Phone Provider
(information only used for our text message appointment reminders)

Email
(only used in-house, never given out to 3rd parties)

How did you find us? Occupation/Employer

Emergency Contact Name Relationship Phone

Please describe what is going on:

____
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____
____
____
____

What result would you like to achieve:

____
____
____

In your opinion, how would you rate your overall health?

poor 1 2 3 4 5 6 7 8 9 10 great

Are you on any medication? Yes (list below) No

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____
____

Have you been seen by another doctor in the last year?
Yes (describe below) No

____
____

Personal Health History (please check the box of any that are relevant to your history)

Cancer	High Blood Pressure	Head Trauma	Car Accidents	Facial Pain	Smoker (daily/social)
MS	Allergies	Concussion	Broken Bones	Neck Pain	Alcohol (daily/social)
Diabetes	Sleeping Trouble	Headaches	Surgery	Mid-Back Pain	Caffeine(daily/social)
Parkinson's	Fatigue	Migraines	Joint Replacement	Low Back Pain	Poor Diet
Tuberculosis	Digestive Disorder	Depression	Hysterectomy	Arm Pain	No Exercise
Seizures	Sinus Trouble	Anxiety	Hearing aids	Hand Pain	Artificial Sweeteners
Heart Trouble	Ear Trouble/Ringing	Dizzy/Balance Issues	Dentures	Leg/Foot Pain	Yearly Flu Shot
Alzheimer's	Asthma	Numbness/Tingling	Arthritis	Other___________	Stress

For Women Only: Are you Pregnant? Yes No Unsure Date of Last Period:__________ Menstrual Cramps? Yes No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend of terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Vital Force Clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Gaurdian's) Signature Date