Valley Wellness & Chiropractic, Inc.

Welcome! Please fill out these information pages so we may better serve you.

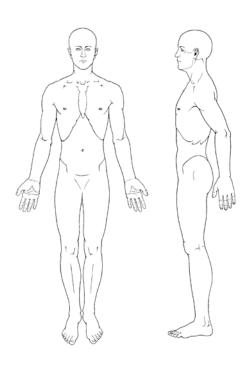
(present insurance information and identification to office staff)

PLEASE PRINT CLEARLY.	TODAY'S DATE:					
Full Name:	Sev. Age	Date of Riv	rth:			
Address:	City/State/Zin:	Date of Di	rui			
Address:	(work)		(cell)			
Employer:	(work)		(ccii)			
Social Socurity #:	Duties	Work Status:	full time	nort time	n rotiro	d
Social Security #:	Mayrwa	work status.	luli tillie, _	part time	e, reure	J
Eman address:	Nay we	eman you: YES	_ NO	004		
Spouse, Parent, or Guardian:		Age: Birth D	ate:	55#:		
Their employer:	Their Phone: (cel	II)	(wo	ork)		
In Case of Emergency Contact: Phone: (cell) How did you hear about our practice or where the contact of the c		Relationsl	hıp:			
Phone: (cell)	(home)		(work)			
How did you hear about our practice or wh	o may we thank for referi	ring you?				
Гуре of payment; Cash, Credit Card,	Your auto insurance, H	ealth Insurance, N	//dicare, C	Other		
(place a check mark for only on	·	ore than one cond	lition then fi	ill out rest		2 0 .
HeadacheNeckShoulder/A Ear Infections, Chiropractic Wellness						
When did condition Start:	Is con	ndition getting; wor	rse, bette	er, or s	taying the	same
How did condition start:						
Did the condition begin: Gradually, S	Sudden, or Progress ov	er time				
How often do you experience your conditatermittently (0-25% of day), Occa		, Frequently (51-75%	%), Cor	nstant (76-1	100%)	_
What makes worse? Bending, lifting_ sneezing, driving, riding, pushi	_, twisting, sitting, s ng, pulling, watchi	tanding, walking ing TV, reading_	, running, housewo	, laying rk/work	, cough _, other	iing,
What causes relief? Nothing, rest, e	xercise, bracing, sitti	ng, standing, la	ying, heat_	, cold,	other	
Does this condition interfere with your;	work, sleep, social	l life, home dutie	es, recreat	ion, oth	ier	
Does the pain radiate into; shoulder, a	rms, elbow, fingers_	_, buttocks, hips_	_, legs, kne	e, feet	, toes	
Type of pain; sharp, dull, ache, bu	rn, throb, numb, ti	ngling, other				
Feels worse in; morning, afternoon	_, evening, middle of r	night, after activi	ties			
HOW DOES THE	S CONDITION FEEL T	ODAY? (circle a nu	umber that b	est describ	oes)	
0 1 2 No pain	3 4	5 6	7	8	9	10 Unbearable
Who have you seen about this and dates When and what treatments have you re	?					
				other		
The results of previous treatments were						
What test have been performed and who	en: A-rays, NIKl	, CA1 scan	_, otner			
Have you had similar problems in the pa	ast: when and what?					
What treatments might have you receive						
Previous Chiropractic? When	: wny?	Kesuits	-C-1 '			
In what position do you sleep? Back, S Do you sleep with a pillow? Yes, No	Side, Stomach _ How many and	How many hours what type?	or steep do y	ou get?		

(ANY OTHER CONDITIONS YOU WANT US TO KNOW ABOUT?)

Other – describe When did condition start:				er/Arm/Elbow/Hand		L	ow-Back	Leg/Kne	e/Foot	
When did condition start:	Other – desci	ibe								
Did the condition begin: Gradually, Sudden, or Progress over time? How often do you experience your condition? Intermittently (0-25% of day), Occasionally (26-50%), Frequently (51-75%), Constant (76-100%) What makes worse? Bending_, lifting, stisting, stitting, standing, walking, running, laying, coughing, sneezing, driving, riding, pushing, pulling, watching TV, reading, housework/work, other What causes relief? Nothing, rest, exercise, bracing_, sitting, standing, laying, heat, cold, other Does this condition interfere with your; work, sleep, social life, home duties, recreation, other Does the pain radiate into; shoulder_, arms_, elbow, fingers, buttocks, hips, legs, knee, feet, toes Type of pain; sharp, dull, ache, burn, throb, numb, tingling, other Feels worse in; morning, afternoon, evening, middle of night, after activities HOW DOES THIS CONDITION FEEL TODAY? (circle a number that best describes) 0	When did co	ndition start	t:		Is condition g	etting wo	rse, bett	er, or st	aying the sa	ame
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Does the pain radiate into; shoulder, arms, elbow, fingers, buttocks, hips, legs, knee, feet, toes Type of pain; sharp, dull, ache, burn, throb, numb, tingling, other Feels worse in; morning, afternoon, evening, middle of night, after activities HOW DOES THIS CONDITION FEEL TODAY? (circle a number that best describes) 0 1 2 3 4 5 6 7 8 9 10 No pain Unbearable pain Who have you seen about this and dates? When and what treatments have you received? The results of previous treatments were; not effective, poor, good, very effective, other What test have been performed and when? X-rays, MRI, CAT scan, other Have you had similar problems in the past? When and what?										
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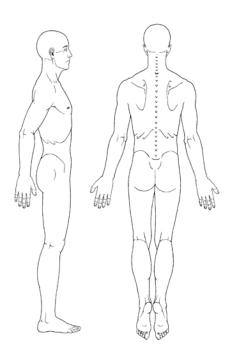
PAIN LOCATION



Please circle the area on the diagram that indicates where your condition(s) is.

Then mark on the diagram by using the letters below to indicate what type of condition(s) you are experiencing.

 $oldsymbol{X} = \mbox{PAIN, DISCOMFORT}$ $oldsymbol{N} = \mbox{NUMBNESS}$ $oldsymbol{T} = \mbox{TINGLING}$ $oldsymbol{B} = \mbox{BURNING}$



Other Symptoms past or present: (Check all that apply)

Many patients are surprised to find out that chiropractic and/or wellness care may help many of the below conditions, feel free to ask how your condition may also be affecting the above complaints. □ Poor Appetite □ Neck Problems □ Dizziness/ □ Hyperactivity/ Vertigo □ Arm problems □ Backaches Behavioral □ Leg problems □ Earaches □ Fainting □ Growing pains □ Blood disorders □ Diabetes □ Urinary □ Breathing problems □ Stomach aches □ Colds/Flu □ Bed Wetting □ Irritability □ Migraines □ Convulsions □ Sore throats □ Depression □ Arthritis □ Loss of smell □ Loss of balance □ Insomnia □ Muscle jerking □ Bronchitis □ Joint Pain □ Walking □ Cancer problems □ Coordination □ Osteoporosis □ Epilepsy □ Muscle Cramps □ Broken bones □ Acid Reflux. ☐ Heart Problems □ Bone fractures □ Ruptures □ Anemia □ Hernias The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of yours. Car accidents 5+ ___ 3-4 ___ 1-2 ___ Please describe any injuries or treatment: Which of the following sports have you been involved in? □ Cheerleading □ Football □ Horseback □ Basketball □ Soccer □ Martial Arts □ Gymnastics □ Baseball Other: Have you or do you? □ Fallen down the □ Broken a bone if □ Perform stairs so, which one(s)? repetitive tasks □ Slipped/Fell on (typing/lifting/etc.) the ground what are they? □ Sports injury □ Sit more than 4 □ Stress or strain hours per day □ Drive more than while working 2 hours per day \square Exercise: \square 1-3x wk \square 4-7x wk. \square None. Member of a health club or gym? \square Yes \square No. Circle all prescription and non-prescription medicines you are taking: □ Anti-Depressant □ Asthma Other: □ Tylenol □ Anxiety □ Advil/Ibuprofen □ Sleep Aids □ Cold/Allergy □ Blood Thinners □ Blood Pressure □ Hormones □ Muscle Relaxors □ Attention Aids

Do you take any Vitamins or Herbs?

Yes

No _____