Valley Wellness & Chiropractic, Inc.

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

PLEASE PRINT CLEARLY. **TODAY'S DATE:** _____

Full Legal Name: _____ **Preferred Name:** _____

Sex: _____ **Age:** _____ **Date of Birth:** _____ **Social Security #:** _____

Street Address: _____ **City/State/Zip:** _____

Cell Phone _____ **Work Phone** _____ **Home Phone** _____

Email contact address: _____

Who can we thank for your referral? _____

Name of Spouse, Parent, or Guardian: _____

Employment: __Full Time, __Part Time, __Unemployed, __Retired, __Military, __Disability

Occupation_____
Employer_____

Emergency Contact_____ **Phone #**_____

Payment Information: Please check all that may apply.

Cash/Check__, Credit/Flex/Debit Card__, Health Insurance__, Medicare__, Your Auto Ins.__, Attorney__, Other_____

Are you experiencing? __Neck Pain, __Back Pain, __Headaches, __Shoulder Pain, __Hip Pain, __Other_____

Is this pain from a recent Auto Collision? _____ Date of Collision_____

Who is the attorney handling your case? _____

Health Insurance Information:

Name of Primary Insurance Carrier_____ Policy ID#_____

Name of Policy Holder (if not you) _____ Policy Holder Birthdate_____

Policy Holder Social Sec. # _____ Policy Holder is: __Spouse, __Parent, __Guardian, __ Other_____

Policy Holder's phone/cell # _____ Their employer _____

Name of Secondary Insurance Carrier_____ Policy ID#_____

Name of Policy Holder (if not you) _____ Policy Holder Birthdate_____

Policy Holder Social Sec. # _____ Policy Holder is: __Spouse, __Parent, __Guardian, __ Other_____

Policy Holder's phone/cell # _____ Their employer _____

Review of Systems

Check all that apply & leave blank if it does not apply to you.

Have you had any of the following musculoskeletal (bone/muscle-related) issues?

□Poor Posture	□Disc Problem	□Pinched Nerve	□Midback Pain	□Arm Pain
□Knee Pain	□Scoliosis	□Spondylosis	□Broken bones	□Gout
□Osteoarthritis	□Spinal break	□Spinal surgery	□Joint disorders	□Arthritis

Have you been diagnosed with or use the following treatments?

□ Anticoagulant use	□ Benign Bone Tumors of the Spine	□ Articular Hypermobility Disease
□ Osteoporosis	□ Bleeding Disorders	□ Rheumatoid Arthritis
□ Ankylosis Spondylitis	□ Unstable (C2) OS Odontoid	□ Malignancies or Bone Cancers
□ Spine Infections	□ Myelopathy	□ Cauda Equina Syndrome

□ Strokes/TIA's/Vertebrobasilar Insufficiency Syndrome □ Major Artery Aneurysm or Blood Clots
□ Radiating Pain, Numbness, or Weakness into the arms or legs

Pulmonary (lung-related) issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____

Cardiovascular (heart-related) issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs □ Heart attacks □ Heart disease

□ Angina □ Hypertension □ Pacemaker □ Irregular heartbeat □ Other _____

Neurological (nerve-related) issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ Seizures

□ One-sided decreased feeling in the face or body □ Vertigo □ Loss of sense of smell □ Other _____

Endocrine (glandular/hormonal) related issues or procedures?

□ Thyroid disease □ Hormone therapy □ Steroid replacements □ Diabetes □ Other _____

Renal (kidney-related) issues or procedures?

□ Kidney stones □ Incontinence □ Bladder Infections □ Dialysis □ Other _____

Gastroenterological (stomach-related) issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □Hernia
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Liver disease □ Reflux/heartburn

Hematological (blood-related) issues?

□ Regular aspirin use □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)

□ Sickle-cell anemia □ Anemia □ Other _____

Dermatological (skin-related) issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriasis □ Eczema □ Other _____

Psychological issues?

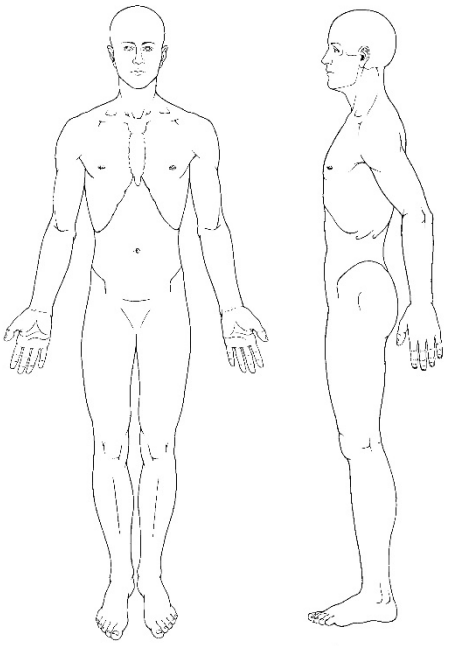
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Other _____

General issues?

□Fatigue □Fainting □Light headed upon rising □Under Stress □Trouble Sleeping □ Other_____

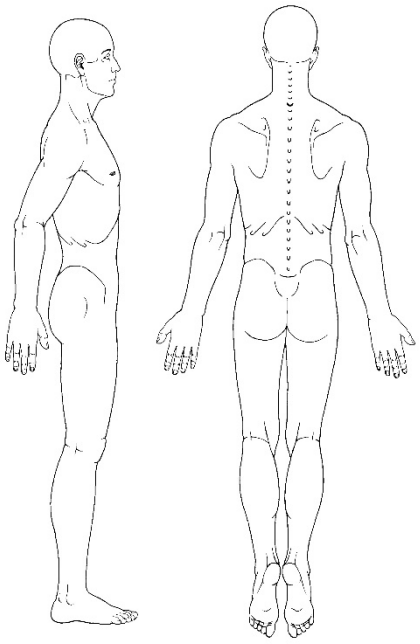
Patient Name: _____ Date: _____

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.

X = PAIN, DISCOMFORT
N = NUMBNESS
T = TINGLING
B = BURNING



Symptom 1: What is bothering you the most today?

_____

HOW INTENSE IS THE PAIN TODAY? (circle a number that best describes)

_____

0 1 2 3 4 5 6 7 8 9 10
No pain
Unbearable pain

When did condition Start: _____ **Is condition getting:** worse____, better____, the same___

How did condition start?

_____

Did the condition begin? Gradually___, Sudden___, Progress over time___

How often is your condition?
Intermittent (0-25% of day) ___, Occasional (26-50%) ___, Frequent (51-75%) ___, Constant (76-100%)
_____

What makes worse? Bend__, lift__, twist__, sit___, sit to stand__, stand___, walk___, run___, lay___, cough___, sneeze___, drive___,
push___, pull__, read___, housework___, work___, child care___,
other_____

What brings relief?

_____
____

Does this condition interfere with? work__, sleep__, social life__, home duties__, recreation__,
other_____

Does the pain radiate? shoulder__, arms__, elbow__, fingers__, buttocks__, hips__, legs__, knee__, feet__, toes__

Is the pain? sharp__, dull__, ache__, burn__, throb__, numb__, tingling__,
other_____

Feels worse in; morning___, afternoon___, evening___, middle of night___, after activities____, other _____

Who have you seen about this & diagnosis?

_____

What treatments have you received & when?

_____

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_____

Patient Name: _____ Date: _____

Symptom 2: What else is bothering you today?

_____

HOW INTENSE IS THE PAIN TODAY? (circle a number that best describes)

0 1 2 3 4 5 6 7 8 9 10

No pain
Unbearable pain

When did condition Start: _____ **Is condition getting:** worse____, better____, the same___

How did condition start?

_____

Did the condition begin? Gradually___, Sudden___, Progress over time___
How often is your condition?
Intermittent (0-25% of day) ___, Occasional (26-50%) ___, Frequent (51-75%) ___, Constant (76-100%) _____

What makes worse? Bend__, lift__, twist__, sit___, sit to stand__, stand___, walk___, run___, lay___, cough___, sneeze___, driving___, push___, pull__, read___, housework ___, work___, other_____

What brings relief?

_____

Does this condition interfere with? work__, sleep__, social life__, home duties__, recreation__, other_____

Does the pain radiate? shoulder__, arms__, elbow__, fingers__, buttocks__, hips__, legs__, knee__, feet__, toes__
Is the pain? sharp__, dull__, ache__, burn__, throb__, numb__, tingling__, other_____
Feels worse in; morning___, afternoon___, evening___, middle of night___, after activities____, other _____
Who have you seen about this & diagnosis?

_____

What treatments have you received & when?

_____

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_____

Symptom 3: What else is bothering you today?

_____

HOW INTENSE IS THE PAIN TODAY? (circle a number that best describes)

0 1 2 3 4 5 6 7 8 9 10

No pain
Unbearable pain

When did condition Start: _____ **Is condition getting:** worse____, better____, the same___

How did condition start?

_____

Did the condition begin? Gradually___, Sudden___, Progress over time___

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How often is your condition?
Intermittent (0-25% of day) ___, Occasional (26-50%) ___, Frequent (51-75%) ___, Constant (76-100%) _____

What makes worse? Bend__, lift__, twist__, sit___, sit to stand__, stand___, walk___, run___, lay___, cough___, sneeze___, driving___, push___, pull__, read___, housework ___, work___, other_____

What brings relief?
_____
___
Does this condition interfere with? work__, sleep__, social life__, home duties__, recreation__, other_____

Does the pain radiate? shoulder__, arms__, elbow__, fingers__, buttocks__, hips__, legs__, knee__, feet__, toes__
Is the pain? sharp__, dull__, ache__, burn__, throb__, numb__, tingling__, other_____
Feels worse in; morning___, afternoon___, evening___, middle of night___, after activities____
Who have you seen about this & when?
_____
What treatments have you received & when?
_____
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_____

Patient Name: _____ Date: _____

Answer if these topics relate to you or leave blank if not.

Past Health History:

A. When was the last time you saw your Primary Doctor & why?_____

_____

B. What is your current height and weight? _____

C. List previous injury, concussion, or trauma (auto collision, falls, sports, stairs, etc.) & When?

_____

_____

D. Have you ever broken or dislocated any bones? Which bones? Joint replacement? Metal Implants/Screws?

_____

E. Allergies: _____

F. Medications: □Muscle Relaxer □Pain Reliever □Arthritis □Anxiety □Insulin □Depression
□Blood Pressure □ADD/ADHD □Over the Counter/Other: _____

G. Any Surgery or Hospitalizations: _____

_____

H. Females: Are you currently Pregnant? □ YES □ NO

Any complications with prior birth processes? _____

Family Health History: (Mom, Dad, Siblings)

Do you have a family history of?

□ Spinal Decay □ Scoliosis □ Back Problems □ Disc Problems □ Headaches □ Cancer □ Diabetes

□ Stroke/TIA □ Osteoporosis/Osteopenia □ Neurological Disorders □ Heart Disease

□ Other: _____

Your Social & Occupational History:

A. Job/School description: □Sit over an hour at a time □Use tablet, smartphone, or laptop

□Stand over an hour at time □Computer □Light Labor □Heavy Labor □Drive an hour or more daily

□Other:_____

B. Exercise: □None □Occasional □Daily □Weekly □Other _____

C. Recreation/Hobbies: _____

D. Lifestyle: □Smoke, how much? _____ □Alcohol, how often? _____ □Caffeine, cups per day? _____

E. What are you currently doing to improve your health? _____

F. Have participated in any programs to maximize the stability of your spine? _____

Patient Name: _____ Date: _____