Today's Date:_____ Email:_____

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Sex: ☐ M ☐ F Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell: _____ Work: _____

Preferred Name: _____ Who referred you to our office? _____

Have you undergone chiropractic care before? ☐ Yes ☐ No

When _____ Where _____

Employment Information

Employment Status: ☐ Employed ☐ Part-Time Student ☐ Full-Time Student ☐ Other

Employer:_____ Occupation:_____

Address: _____ City, State, Zip: _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone #: _____ Relationship To Patient: _____

Occupation: _____ Employer: _____ Phone: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If work related, has employer been notified? ☐ Yes ☐ No Employer Contact: _____

Employer Contact Phone and Extension: _____

Medical/Family History

Please indicate which conditions you have been experiencing (using key above) by marking appropriate boxes.

☐ AIDS ☐ anemia

- ☐ arthritis
- ☐ asthma
- ☐ back pain
- ☐ bladder trouble
- ☐ bone fracture
- ☐ bowel control loss
- ☐ cancer
- ☐ concussion
- ☐ convulsions
- ☐ diabetes
- ☐ dislocated joints
- ☐ dizziness
- ☐ earache
- ☐ epilepsy
- ☐ fatigue
- ☐ headaches
- ☐ heart trouble
- ☐ high blood pressure
- ☐ HIV
- ☐ indigestion
- ☐ kidney disorders
- ☐ menstrual cramps
- ☐ multiple sclerosis
- ☐ neck pain
- ☐ nervousness
- ☐ night sweats
- ☐ numbness
- ☐ poor circulation
- ☐ reproductive trouble
- ☐ serious injury
- ☐ sinus trouble
- ☐ stroke
- ☐ spinal curvature
- ☐ thyroid problem
- ☐ weakness
- ☐ weight gain/loss
- ☐ other _____

Have you been treated by a physician for any health condition in the last year? ☐ No ☐ Yes

Describe Condition: _____ Date of Last Physical Exam: _____

Primary Medical Doctor's Name: _____ **Phone:** _____

Surgical History

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? ☐ No ☐ Yes Any other implants? _____

Accident History

1. _____ ☐ Job ☐ Auto ☐ Other
2. _____ ☐ Job ☐ Auto ☐ Other
3. _____ ☐ Job ☐ Auto ☐ Other

Primary Complaint(s)

My health goals are: ☐ correction/stabilization ☐ health maintenance ☐ pain relief

Please check the area(s) of complaint: ☐ neck

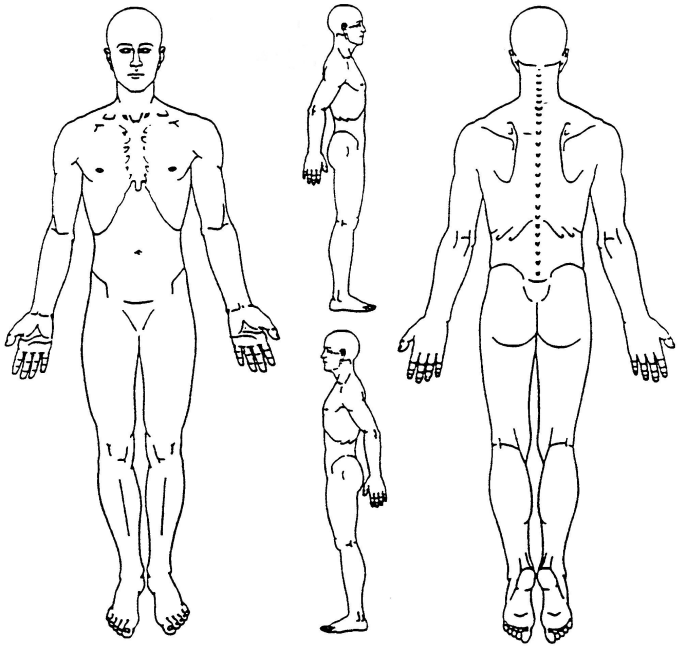
39 Central Street, Woodstock, VT 05091 Tel: (802) 291-2288
Mailing Address: 76 Keyes Mountain Road, Reading, VT 05062

☐ headache
☐ shoulder
☐ arm ☐ hand ☐ right ☐ left
☐ mid-back
☐ low back
☐ hip/buttock ☐ right ☐ left
☐ leg ☐ right ☐ left
☐ foot

How does the pain feel?

N = numbness **T** = tingling **P** = pain

B = burning **A** = ache



When did the pain begin?

Approximate Date: _____

☐ Gradually without incident

☐ With specific incident

What activities aggravate your condition?

☐ Bending ☐ Coughing ☐ Lifting ☐ Reaching
☐ Lying Down ☐ Standing ☐ Sitting ☐ Walking
☐ Straining at Stool ☐ Turning Head ☐ getting out of chair ☐ looking down ☐ Other: _____

_____

What activities relieve your condition?

_____

How Much Does It Hurt?

(Circle the number that best describes your pain level)

1 2 3 4 5 6 7 8 9 10

none --> annoying --> uncomfortable --> dreadful --> horrible --> agonizing

When and how did it occur? _____

_____

_____

_____

Symptoms: ☐ Come & Go ☐ Constant **Worse in the:** ☐ Morning ☐ Afternoon ☐ Evening

Have you ever had this before? ☐ No ☐ Yes If so, when? _____

Name and location of doctors previously seen for present condition(s):_____

_____

If you could guess, what do you think is causing your complaint(s)? _____

39 Central Street, Woodstock, VT 05091 Tel: (802) 291-2288
Mailing Address: 76 Keyes Mountain Road, Reading, VT 05062

Are you taking any medication? ☐ No ☐ Yes What Kind? _____

Are you taking any supplements? ☐ No ☐ Yes What Kind? _____

Are you pregnant? ☐ No ☐ Yes Date of last menstrual period (*onset*) _____

Have you ever used tobacco? ☐ Never ☐ Previously ☐ Daily ☐ Weekly ☐ Monthly

Alcohol Consumption ☐ Never ☐ Previously ☐ Daily ☐ Weekly ☐ Monthly

Please Check Additional Symptoms You May Be Experiencing

☐ ankle swelling ☐ blurred vision ☐ buzzing in ears ☐ cold hands ☐ cold feet ☐ chills
☐ concentration loss/confusion ☐ constipation ☐ depression ☐ diarrhea ☐ difficulty breathing
☐ face flushed ☐ fainting ☐ fever ☐ frequent colds ☐ gall bladder problems ☐ insomnia
☐ light bothers eyes ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ muscles jerking
☐ nausea ☐ shortness of breath ☐ sore throat ☐ stomach pain ☐ tremors ☐ wheezing

Are you concerned about any of the following symptoms?

(please check all that apply)

GENERAL HEALTH

☐ Cold/Flu Symptoms
☐ Immune System Support
☐ Calcium Deficiency
☐ Iron Deficiency
☐ Mineral Deficiency
☐ Superfood Deficiency
☐ Vitamin B Deficiency
☐ Vitamin C Deficiency

ENERGY

☐ Constant Fatigue & Exhaustion
☐ Blood Sugar High/Low

EMOTIONAL HEALTH

☐ Anxiety
☐ Depression
☐ Irritability
☐ Mental Fatigue

39 Central Street, Woodstock, VT 05091 Tel: (802) 291-2288
Mailing Address: 76 Keyes Mountain Road, Reading, VT 05062

WHOLE FOOD NUTRITION SYMPTOM SURVEY (optional)

Take this survey to find out which supplements will best support your health concerns.

RESPIRATORY

SKIN

☐ Acne
☐ Bruising
☐ Cellulite
☐ Dry Skin
☐ Itchy Scalp/Dandruff

MOUTH

☐ Bleeding Gums
☐ Mouth Sores
☐ Sensitive Teeth
☐ Weak Teeth

MUSCLE/BONES

☐ Breathing Problems
☐ Asthma
☐ Brittle Bones & Bone Soreness
☐ Growing Pains
☐ Muscle Strains

HEART

☐ Cholesterol
☐ Heart Concerns

CIRCULATORY

☐ Hands, Arms, Legs Fall Asleep
☐ Poor Circulation
☐ Restless Legs
☐ Spider Veins
☐ Tingling Fingers/Toes

DIGESTION

☐ Gas & Bloating
☐ Ulcers

WOMEN'S HEALTH

☐ Menopause
☐ PMS
☐ Pre-Natal Support

MEN'S HEALTH

☐ Erectile Dysfunction
☐ High Blood Pressure
☐ Prostate Support

Authorization for Medical Records & Reports

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners.

Patient's Signature (parent if minor): _____ **Date:** _____

Financial Policy

I agree to be responsible for payment of all services rendered on my behalf and of my dependents. Should I decide to submit receipts from this office to my insurance carrier for reimbursement, I understand that they may pay less than the actual bill for services or nothing at all.

Explanation of Fees:

New Patient Comprehensive Service - 100 - Services include initial patient intake, comprehensive history, examination, recommended treatment plan to reach individual health goals, and initial treatment.

Office Visit - 50 - 20 minutes. Chiropractic joint manipulation with targeted soft tissue release therapy.

Extended Visit - 90 - 40 minutes. Additional soft tissue and/or rehabilitative therapies.

Hour Visit - 135 - 55 minutes. To address multiple regions or complex conditions.

Cash, check, visa, mastercard, American Express, Discover, FSA, and HSA accounts are acceptable.

Unused pre-pay plans may be reimbursed in full minus 50 dollars per office visit used.

Patient's Signature (parent if minor): _____ **Date:** _____

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature (parent if minor): _____ **Date:** _____

Informed Consent for Chiropractic Care

All health care professional (anesthesiologists, chiropractors, dentists, medical doctors, osteopathic, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any risks and/or complications. Informed consent information regarding any risks does not necessarily indicate an error in clinical judgement. No guarantee of cure or results has been made to you, the patient, in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery and does not diagnose internal and/or medial conditions.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited, inherent risks. These seldom occur; not enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care. All health care procedures have some risks. With chiropractic adjustments the risk may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome, or stroke. The chances of these risks occurring have been estimated by experts to be approximately 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks and you will be notified in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgement during my course of care, based upon the facts then known. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions and I acknowledge that no guarantee of cure has been made to me concerning results and treatment.

Patient's Signature (parent if minor): _____ **Date:** _____

39 Central Street, Woodstock, VT 05091 Tel: (802) 291-2288
Mailing Address: 76 Keyes Mountain Road, Reading, VT 05062