

Patient Health Record

Welcome to



Welcome

Welcome to Vitality Chiropractic. The office of Doctors Grace and David Basista. We are glad you are here, because we are here to serve by helping you to achieve vital health.

Please complete this confidential Patient Health Record completely and accurately. If you have any questions, please ask any one of our team.

Here's to Your Health,

Dr. David
Dr. Grace

About You

Name _____ MALE FEMALE

What do you prefer to be called? _____ Birthdate ____/____/____ Age _____

Drivers License # _____ State _____

Do you observe birthdays or holidays? YES NO

Address _____

CITY,

STATE

ZIP

Hm Phone # _____ Wk # _____ Mobile # _____

Fax # _____ E-Mail Address _____

Employer _____ Occupation _____

Emp. Address _____

CITY

STATE

ZIP

Your Marital Status; SINGLE MARRIED DIVORCED SEPARATED WIDOWED

Spouse's Name _____ Names/ ages of children; _____

one

two

Reason for this Visit

The reason for this visit/chief complaint _____

When did this condition begin? _____ Gradual or Sudden?

As the result of? SPORTS INJURY WORK INJURY AUTO ACCIDENT FALL OTHER

Have you had this/or similar before? YES NO When? _____ How often? _____

If so, please explain _____

Is this condition effecting any other area of your body? YES NO If yes, explain _____

Is it getting worse? YES NO CONSTANT COMES AND GOES

Is it interfering with your? WORK SLEEP DAILY ROUTINE FAMILY LIFE OTHER

If so, please explain _____

What have you found relieves this? _____

What have you tried that hasn't relieved this? _____

What have you found aggravates this? _____

If this went without care, how do you think it would affect you? _____

three

Health History

Do you have any other health conditions? YES NO _____

Are you taking any of the following drugs? PROZAC INSULIN ANTI-DEPRESSANT/DEPRESSANTS

MUSCLE RELAXERS BLOOD PRESSURE MEDICATION PAIN KILLERS (INCLUDING ASPIRIN)

THYROID REPLACEMENT Others _____

Have you ever had any of the following diseases /health conditions?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> HEART SURGERY/ PACEMAKER | <input type="checkbox"/> HEART ATTACK/ DISEASE | <input type="checkbox"/> STROKE OR TIA | <input type="checkbox"/> HIGH/ LOW B.P. |
| <input type="checkbox"/> SEVERE OR FREQUENT HEADACHES | <input type="checkbox"/> POOR CIRCULATION | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> FAINTING/ SEIZURES/ EPILEPSY | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> BLADDER PROB/ BEDWET. |
| <input type="checkbox"/> MENSTRUAL PROB./ INFERTILITY | <input type="checkbox"/> ALCOHOL/ DRUG ABUSE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> HEPATITIS/ LIVER PROB. |
| <input type="checkbox"/> ULCERS/ REFLUX/ DIGESTION PROB | <input type="checkbox"/> HERPES/ SHINGLES | <input type="checkbox"/> HIV+/ AIDS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> CANCER/ CHEMOTHERAPY | <input type="checkbox"/> FREQUENT NECK PAIN | <input type="checkbox"/> DIABETES | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ASTHMA/ BREATHING PROBLEMS | <input type="checkbox"/> ALLERGIES/ SINUS PROB. | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> OTHER _____ |

Please list anything that you may be allergic to: _____

Please list previous surgeries/ hospitalization with dates: _____

Please list any **past** serious accidents: _____

Have you had spinal X-Rays recently? YES NO When? _____

For women; Are you taking Birth Control? YES NO

Are you pregnant? YES NO How long? _____ Are you nursing? YES NO

Experience with Chiropractic

five

Whom may we thank for referring you? _____

Have you ever been to a Chiropractor? YES NO Whom? _____

When? _____ What was the reason for those visits? _____

What were your results? _____

Has any *adult* in your family seen a Chiropractor? YES NO

Has any *child* in your family seen a Chiropractor? YES NO

six

In Case of Emergency

Whom should we contact? _____

Relationship? _____

Home Phone # _____

Wk # _____ Mobile # _____

seven

Authorization for Care

I hereby authorize the Doctor to work with my condition as he/she deems appropriate through the use of adjustments to my spine. The sole goal of said adjustments, being the detection and correction of vertebral subluxations only (Spinal misalignments causing Nervous System interference.) I understand, as with any treatment, there is some risk involved in receiving Chiropractic adjustments. The Doctor will not be treating me for any pre-existing medically diagnosed conditions, nor giving me any medical diagnosis.

I also understand and agree that the fees for all services rendered me are my sole responsibility. Also, that those fees are due and payable at the time services are received, unless previous arrangements have been made. In addition, fees paid for X-rays are for the examination of the X-rays only. The films will remain the property of this office, available to be seen at any time while I am a patient in this office.

I, _____ have read and fully understand the above.
PRINT NAME

PATIENT'S SIGNATURE

DATE

GUARDIAN'S SIGNATURE AUTHORIZING CARE

DATE

... AND LASTLY, EXPECT A MIRACLE!