

# Van Zeilen Family Chiropractic & Wellness Center

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Age \_\_\_\_\_ D.O.B \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Have you seen a chiropractor before? \_\_\_\_\_ When? \_\_\_\_\_  
 Number of Children \_\_\_\_\_ Names/Ages \_\_\_\_\_ Referred by \_\_\_\_\_  
 Spouse's name \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Office Number \_\_\_\_\_  
 Medications \_\_\_\_\_  
 Surgeries \_\_\_\_\_  
 Auto Accidents \_\_\_\_\_ Serious Falls/Traumas \_\_\_\_\_

Is your condition due to a work injury?    Yes    No  
 Is your condition due to an auto accident?    Yes    No  
 Is there any chance you are pregnant?    Yes    No  
 How did you hear of our office? \_\_\_\_\_

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

## Health History

What is your major complaint? \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_  
 Has any other doctor's treated you for this? \_\_\_\_\_

**Please Circle All That Apply:**

**1. Growth and Development:**

Was your birth traumatic?	Y	N	UNSURE
Did you suffer from any type of childhood illness?	Y	N	UNSURE
Did you have any childhood accidents/serious falls?	Y	N	UNSURE
Did you have any childhood surgeries?	Y	N	UNSURE
Did you experience any other childhood traumas?	Y	N	UNSURE

**Chiropractor's Comments**

**2. Current Health Habits:**

Do/Did you smoke?	Y	N
Do you try and eat healthy?	Y	N
Do you currently take prescriptive/non-prescriptive drugs?	Y	N
Do you exercise regularly?	Y	N
Do you have occupational stress?	Y	N
Do you have mental/emotional stress?	Y	N
Do you have physical stress?	Y	N
Do you have any sport related injuries (past/present)?	Y	N
Sleeping posture? (please check)    ___ side ___ stomach ___ back		

Is there a history of: (please check)

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	___	___	___	___	___
Mother's Side	___	___	___	___	___

**Please check all that you are experiencing:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Neck Pain/Stiffness     | <input type="checkbox"/> Pin/Needles in Arms   | <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Sudden Weight Loss     |
| <input type="checkbox"/> Mid Back Pain/Stiffness | <input type="checkbox"/> Pin/Needles in Legs   | <input type="checkbox"/> Depression             | <input type="checkbox"/> Fainting               |
| <input type="checkbox"/> Low Back Pain/Stiffness | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Loss of Memory         |
| <input type="checkbox"/> Shoulder Pain           | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension                | <input type="checkbox"/> Jaw Problems           |
| <input type="checkbox"/> Arm/Hand Pain           | <input type="checkbox"/> Neuritis              | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Bowel/Bladder Problems |
| <input type="checkbox"/> Leg/Knee/Foot Pain      | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Night Pain/Sweats      | <input type="checkbox"/> Tremors                |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Swelling               | <input type="checkbox"/> Restricted Motion      |
| <input type="checkbox"/> Sinus Trouble           | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Excessive Perspiration |   |

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

***As a result of my chiropractic care, I would like to:***

Please "X" all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Feel better quickly    | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle                               |

**1. Release of Information**

I authorize this clinic to release any information pertinent to my case to any insurance company, Adjustor, and/or attorney involved in this case, and hereby release this clinic of any consequence thereof.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**2. Financial Responsibility**

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original. I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature Authorizing Care

\_\_\_\_\_  
Date