VIBRANT SOL CHIROPRACTIC

HEALTH INTAKE FORMS

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

Today's Date_____

Name_____ Age _____ Date of Birth_____

Home Address_____ City _____ State_____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____E-mail address_____

Occupation_____ Employer_____

Business Address_____ City_____ State_____ Zip _____

SS# _____ Emergency contact _____

Marital Status ☐ S ☐ M ☐ D ☐ W ☐ L/W Spouse/Partner _____

Names and Ages of Children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CARE

What concerns do you feel Vibrant Sol Chiropractic can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	School:	Y	N	Exercise/sports:	Y	N
Driving:	Y	N	Walking:	Y	N	Eating:	Y	N
Sleep:	Y	N	Sitting:	Y	N	Love life:	Y	N

When did you first notice these symptoms? _____

Have you ever experienced similar symptoms in the past? When? _____

Was there a certain activity you were doing when you first noticed these symptoms? _____

When this symptom is at its worst, how would you rate the intensity on a scale of 0-10? ___/10

On the same scale of 0 to 10, how would you rate the average intensity of your symptoms? ___/10

Is there anything that makes the symptoms improve? _____

Is there anything that makes the symptoms worse? _____

Does this symptom affect your entire day or does it come and go? _____

HEALTH CARE PRACTIONER HISTORY

Have you ever received Chiropractic care? ☐ Y ☐ N Name of D.C._____ How long under care? ☐ _____days ☐ _____weeks ☐ _____ months ☐ years_____

Date of last visit: _____Why did you stop?_____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

☐ Medical Physician	☐ Acupuncturist	☐ Massage Therapist	☐ Energy Healer
☐ Naturopath	☐ Homeopath	☐ Psychotherapist	☐ Dentist

HEALTH, WELLNESS AND CHIROPRACTIC CARE

FEMALES ONLY

Are you pregnant? Y N Date of last menstrual period: _____ If x-rays are recommended, your signature is required (below) to indicate that you are not pregnant.

Signature: _____Date:_____

If pregnant, Due Date: _____ Name of OBGYN or Midwife _____

Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other_____

PHYSICAL STRESS

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and how they may relate to your present spinal, nerve and health status.

Have you had any **accidents or injuries** in your life related to any of the following? (Check all that apply.)

☐Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse

If yes, state type of **injury and date**:

_____

_____

Have you ever **hurt/injured** your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips?

☐ Y ☐ N

If yes, state type of **injury and date**:

_____

_____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ☐ Y ☐ N

If yes, list **body parts injured and dates**:

_____

_____

Have you ever been hospitalized, including surgery (in-patient or out-patient)? ☐ Y ☐ N

If yes, **state reason and dates**:

_____

_____

Have you ever had any kind of head trauma or concussion? ☐ Y ☐ N

If yes, **state reason and dates**:

_____

_____

Have you ever had an injury that you believe happened due to **poor balance/coordination**? ☐ Y ☐ N

If yes, **please describe**:

_____

_____

Please describe the physical demands of your job: _____

Employer: _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y N	Loss of loved one	Y N	Abuse	Y N
Work or School	Y N	Divorce/separation	Y N	Financial	Y N
Lifestyle change	Y N	Parents divorce	Y N	Illness	Y N

Please list any other emotional stresses you may be experiencing (anxiety, nervousness, depression, etc.)_____

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ☐ Y ☐ N If yes, did you have a reaction? ☐ Y ☐ N

Have you been exposed to any of the following on a regular basis, (past or present)?

☐ Toxic chemicals ☐ Radiation ☐ Second hand smoke ☐ Chemotherapy ☐ Drug therapy ☐ Other

If yes, please list:_____

Do you have allergies to any foods? ☐ Y ☐ N If yes, please list: _____

_____

Do you consume any of the following presently?

☐ Coffee/caffeine ☐ Alcohol ☐ Tobacco ☐ Over the counter drugs ☐ Prescribed drugs

Please list all medications (prescribed and over the counter) _____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your physical health?	☐ Good	☐ Fair	☐ Poor
How do you grade your emotional/mental health?	☐ Good	☐ Fair	☐ Poor
How do you rate your overall "quality of life"?	☐ Good	☐ Fair	☐ Poor
How do you grade your balance/coordination?	☐ Good	☐ Fair	☐ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list:_____

Do you follow a special dietary regime? If yes, what? _____

_____

EXPECTATIONS

Here at Vibrant Sol Chiropractic we take this question very seriously. We sincerely value your health, our results and our relationship with you. We want to fulfill your expectations and goals throughout care. Please take the time to decide exactly what is that you want for your health.

I would like to have the following benefits from chiropractic care: (Check all that apply)

- ☐ Relief of a symptom or problem
- ☐ Relief and prevention of a symptom or problem
- ☐ Healthier spine and nerve system
- ☐ Optimal health on all levels

If you have any specific expectations or apprehensions about your chiropractic care, please identify those here so we can be our best in service to you:_____

_____

_____

I am interested in **brain health/balancing, stress reduction techniques, and/or nutritional counseling**

☐ Y ☐ N

FINANCIAL INFORMATION

Payment in full is expected to be paid at time of service unless other arrangements have been made and agreed upon in writing prior to the service. Due to variations in insurance policy coverage and fee schedule changes, we can provide you with the most accurate quote of coverage over the phone or in person. For information on fees associated with your first visit please contact us at 405.739.0594

INSURANCE

We will need a copy of your driver's license and insurance card to keep on file.

Name of Insurance Co. _____ Policy # _____

Name of Insured: _____ Insured SS# _____ Insured DOB _____

Are you covered by more than one insurance company? Yes No Name of 2nd _____

If this is an Auto Accident or a Work-Related injury, please provide us with the following information:

Name of Auto Insurance Co: _____

Policy or Claim Number: _____

Have you been treated elsewhere? ☐ Emergency Room ☐ Primary Care Doctor ☐ Other_____

What services were provided? ☐ MRI ☐ X-Rays ☐ Medication ☐ Therapy ☐ Other_____

PLEASE READ AND SIGN BELOW

The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give Drs. Ross and Jessica Solis permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. In the event your insurance provider determines that you are not eligible for chiropractic insurance coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by your insurance provider.

Signature_____ Today's Date_____

Thank you for choosing Vibrant Sol Chiropractic. We look forward to optimizing your quality of life.