CONFIDENTIAL INFORMATION

Name: ______________________ Date: ______________________

Email: ______________________ Phone: ______________________

Address: ______________________ City: ____________ Zip: ________

Birth Date: ____________ Age ________ Sex: M F Ocupation: ______________________

Who referred you to the office? ______________________

Whom may we contact in case of emergency? ______________________ Phone: ____________

PLEASE DESCRIBE MAJOR COMPLAINTS IN THE ORDER OF THEIR IMPORTANCE:

____

____

When did this begin? ______________________

What caused it? ______________________

Have you ever had a similar condition before? ______________________

____

Have you ever received treatment? ______________________

If yes, where, when, with what results? ______________________

____

____

____

When did this begin? ______________________

What caused it? ______________________

Have you ever had a similar condition before? ______________________

____

Have you ever received treatment? ______________________

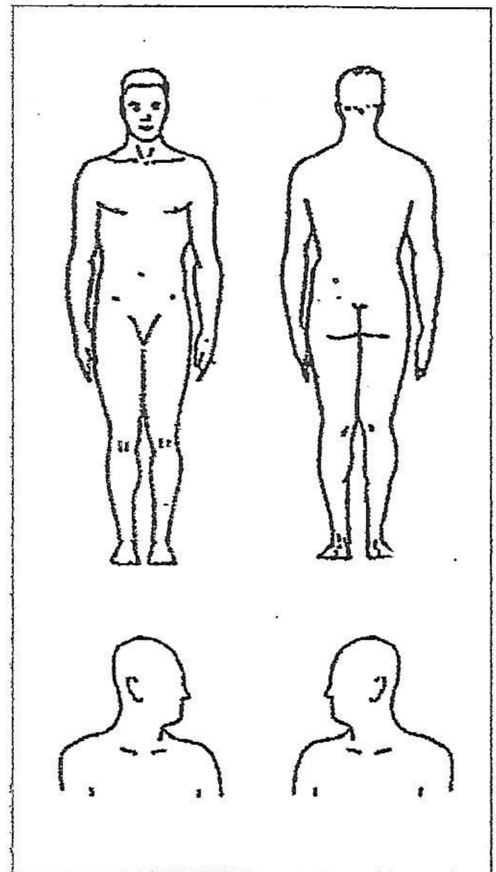
If yes, where, when, with what results? ______________________

____

Other complaints: ______________________

____

PLEASE MARK AREAS OF PAIN BELOW



Which of these factors affect your trouble? (Please check √)

	NO EFFECT	BETTER	WORSE		NO EFFECT	BETTER	WORSE
MOVEMENT				TOWARD THE END OF DAY			
SITTING				DURING MOST ACTIVE TIME			
WALKING				WHILE RESTING			
LYING DOWN				BEFORE MEALS			
DURING THE NIGHT				DURING MEALS			
FIRST THING IN MORNING				AFTER MEALS			
OTHER				OTHER			

CONFIDENTIAL INFORMATION

Name: ______________________ Date ______________

Have you ever suffered from:

- ❑ Dizziness
- ❑ Headaches
- ❑ Anemia
- ❑ Breathing Problems
- ❑ Arthritis
- ❑ Sinus Trouble
- ❑ Diabetes
- ❑ Neuritis
- ❑ Nervousness
- ❑ Heart Trouble
- ❑ Asthma
- ❑ Cancer
- ❑ Venereal Disease
- ❑ Backaches
- ❑ Numbness
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Digestive Disorders

(if you answer any of the following "yes", please explain.)

____

____

____

____

____

Have you ever been hospitalized? *(if yes, explain what was done to you.)* ❑ Yes ❑ No

____

____

____

____

Have you ever, even if you do not think you were hurt, been involved in a vehicular collision? ❑ Yes ❑ No

____

____

____

Have you ever been involved in a bicycle, motorcycle, bus, train or other vehicular accident? ❑ Yes ❑ No

____

Were you ever knocked unconscious? ❑ Yes ❑ No

____

Have you ever used a walker or a cane? ❑ Yes ❑ No

____

Have you ever broken any bones? ❑ Yes ❑ No

____

Have you had any impacts, falls or jolts that you feel specifically may have injured your spine? ❑ Yes ❑ No

____

Have you had extensive dental work performed? ❑ Yes ❑ No

____

CONFIDENTIAL INFORMATION

Name: ______________________________ Date ______________________________

Do you read for prolonged periods? ❑ Yes ❑ No *(if yes, describe position.)*

____

Do you have a particular position for watching TV? ❑ Yes ❑ No *(if yes, describe position.)*

____

Do you play a musical instrument? ❑ Yes ❑ No *(if yes, what kind(s)?)*

____

During the day I? ❑ sit ❑ stand ❑ mechanical work ❑ desk work
❑ drive ❑ phone work ❑ heavy lifting ❑ walk

____

____

____

HABITS Check all that apply:	NEVER	OCCAS.	FREQUENT	DAILY
Coffee (_____ cups per day)	❑	❑	❑	❑
Soft Drinks (_____ per day)	❑	❑	❑	❑
Tobacco (_____ pks per day)	❑	❑	❑	❑
Laxatives	❑	❑	❑	❑
Sleeping Pills	❑	❑	❑	❑
Aspirins, etc.	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

____

____

____

Women Only:

Average duration of menstrual period? ______ days

Average cycle (start to start) ______ days ❑ Regular ❑ Irregular

Are your menstrual periods painful? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Do you experience: ❑ premenstrual tension/depression ❑ vaginal discharge ❑ spotting ❑ light flow ❑ backache ❑ hot flashes ❑ excessive flow ❑ spotting ❑ cramps ❑ congested/painful breasts

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____

Vital Health Care

10400 Griffin Rd. Suite 207 Cooper City, Fl. 33328

PERMISSION & AUTHORIZATION FORMREGARDING THE USE OF "APPLIED KINESIOLOGY" (AK)

PLEASE READ BEFORE SIGNING:

I specifically authorize the Chiropractor at Vital Health Care to perform the AK health analysis and to develop a natural, complementary health improvement program for me, which may include dietary guidelines, nutritional supplements, etc., in order to assist me in improving my health, and not for the treatment, or cure of any disease.

I understand that Applied Kinesiology (AK) is a safe, non-invasive, natural method of analyzing the body's physical, emotional and nutritional needs, and those deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that AK is not a method for "diagnosing" or "treating" any disease including conditions of cancer, AIDS, infections, or other medical conditions, that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of AK testing or any natural health, nutritional, or dietary programs recommended, but rather I understand that AK is a means by which the body's natural reflexes can be used as or aid in determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date:________________ Name____________________________________

Phone:________________ Address__________________________________

Vital Health Care

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RECEIPT OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____ have read a copy of the
Patient Name

Vital Health Cares' Notice of Patient Privacy Practices.

____ ____________________
Signature of Patient or Legal Guardian Date