Wholistic Health Services of Vermont
Patient Confidential Health Record

Today's Date: _____

Name: _____
Address: _____ # Of Children _____
City: _____ Marital Status: M S W D
State: _____Zip Code: _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: □ M □ F
Cell Phone: _____
Fax Number: _____ Occupation:_____
Email Address: _____ Business Phone #_____
Employer: _____
In Case of Emergency Contact: _____ At this Number: _____
Relationship to You is: _____ Referred to This Office By: _____

Please ***circle*** the preferred method of contact**: work, home, cell, email.**

Primary Complaint: _____
Other Doctors Seen for This Condition: □ Yes □ No If Yes, Who? _____
Type of Treatment: _____ Results: _____
How Long Have You Had This Condition: _____or When Did This First Occur: _____
Which Activities Improve Your Conditon: _____Which Aggravate it: _____
Is This Condition Getting, Worse □ Yes, □ No, □ Constant, □ Comes and Goes, □ Other_____
This Condition Interferes With: □ Work, □ Sleep, □ Daily Routine, □ Other_____
How Long has it Been Since You Really Felt Good? _____
This Condition is Related to My: □ Job, □ Auto Accident, □ Home Injury, □ Sports, □ Other_____
If This is a Work or MVA Related Condition Has a Report Been Filed? □ Yes, □ No,
Are You Out of Work for This Condition? □ Yes, □ No,
I Have Seen the Following Professionals for My Condition: _____
Secondary Complaint: _____
Tertiary Complaint: _____
I Take the Following Drugs: _____
I Take the Following Supplements/Vitamins: _____
Age of mattress_____ □ Comfortable □ Uncomfortable, I sleep on my□ side, □back, □stomach
Are you wearing: □ Heel lifts □Sole lifts □Inner Soles □Arch supports □ Night guard

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PAST HEALTH HISTORY

Please Describe Any Surgeries with the Approximate Date: _____
_____
Describe Any Injuries: (sports, fractures, sprains, lifting traumas, falls, car accidents,) _____
_____
Dates and Reasons for Any Hospitalizations: (other than above) _____
_____
Previous Chiropractic Care: □ None □ Dr.'s. Name: _____LastVisit: _____
I Have Allergies to: _____
My Primary Care Physician Is: _____Location: _____

Please Turn This Page Over

What is your willingness to make the necessary changes in your life to get healthier?

☐ Not willing ☐ Somewhat willing ☐ I'm all in!

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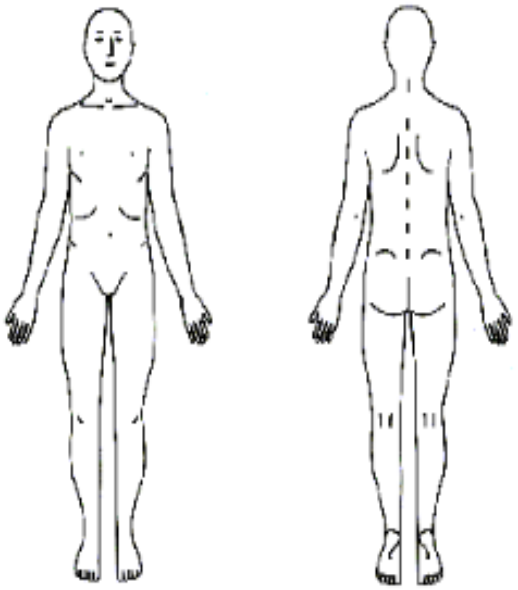
If You Are Here for a Non-Painful Condition, leave the chart below blank. If You Are in Pain Fill out the Chart Below.

Mark all areas of your body where you feel the described sensations. Use the appropriate symbol and mark all areas of radiation.

Numbness ----- Ache *mmm* Stabbing xxxx

Pins & Needles ////// Burning ****



Intensity of Pain Scale, Circle your number

0 1 2 3 4 5 6 7 8 10

No Pain Worst Possible

Do You or Have You Ever Suffered From?

1. Dizziness_____
2. Backaches_____
3. Heart Trouble_____
4. Diabetes_____
5. Arthritis_____
6. Headaches_____
7. Asthma_____
8. Neuritis_____
9. Digestive Disorders_____
10. Nervousness_____
11. Sinus Trouble_____
12. Neck Pain_____

I HEREBY AUTHORIZE THE DOCTOR TO TREAT MY CONDITION AS HE OR SHE DEEMS APPROPRIOATE THE PATIENT ALSO AGREES THAT HE/SHE IS RESPONSIBLE FOR ALL BILLS INCURRED AT THIS OFFICE. THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PREEXISTING MEDICALLY DIAGNOSED CONDITIONS, NOR FOR ANY MEDICAL DIAGNOSIS.

Patient's Signature_____ **Date**_____

Consent to Treat a Minor_____ **Date**_____

Guardian or Spouse's Signature Authorizing Care_____ **Date**_____

PLEASE RETURN THIS FORM TO THE FRONT DESK WHEN COMPLETED. WE WILL BE WITH YOU SHORTLY.