



VERMONT CHIROPRACTIC
& Wellness

NEW PATIENT REGISTRATION

Today's Date _____

Name _____
Last First MI

Address _____
(Complete Mailing) Street Apt# City State Zip

Social Security # _____ - _____ - _____ Date of Birth _____

Primary Phone* (____) _____ - _____ home cell work

Secondary Phone* (____) _____ - _____ home cell work

Email Address: _____*

Employer _____ Occupation _____ Phone (____) _____ - _____

Emergency Contact _____ Relationship _____ Phone (____) _____ - _____

Reason for this visit: routine accident, date _____ illness other: _____

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ Date of Birth _____
Patient's full name

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature _____ Witnessed by _____
(Parent or Legal guardian)



PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

Describe chiropractic problem: _____

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long ago? _____
For what reason?	
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason?	
Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No for serious injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Indicate the drugs do you now take? <input type="checkbox"/> birth control pills <input type="checkbox"/> tranquilizers <input type="checkbox"/> pain killers <input type="checkbox"/> other (specify)	
Do you wear: <input type="checkbox"/> heel lifts? <input type="checkbox"/> sole lifts? <input type="checkbox"/> inner soles? <input type="checkbox"/> area supports? <input type="checkbox"/> negative heels? <input type="checkbox"/> platform shoes?	
What is the age of your mattress? _____ Is it <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable? Do you use a bedboard? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)	

Have you ever: Yes No If yes, briefly explain.

- had a broken bone? Yes No
- been hospitalized? Yes No
- had strains or sprains? Yes No
- used a cane, crutch or other support? Yes No
- been struck unconscious? Yes No
- been hospitalized for other than surgery? Yes No

Do you:

- take minerals, herbs or vitamins? Yes No
- think you need minerals, herbs or vitamins? Yes No
- have any drug allergy? Yes No

When did you last have:

- | | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Never | 0-6 mos. | 6 -18 mos. | longer |
| - spinal x-ray? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - spinal examination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - physical examination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

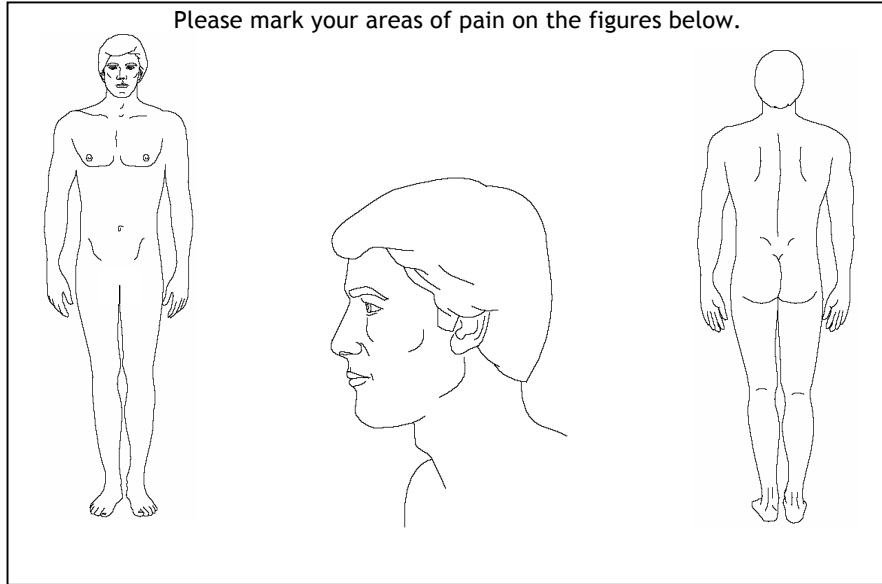
Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

<p>O F C</p> <p>Muscle / Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p>General</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p>Cardiovascular</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>Genitourinary</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p>O F C</p> <p>Eye, Ear, Nose and Throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p>O F C</p> <p>Skin</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>Pain or numbness in</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p>Respiratory</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>Women only</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many months? _____ How many children do you have? _____</p>	<p><i>Check any of the following conditions you currently have or have had:</i></p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> Cholera</p> <p><input type="checkbox"/> Cold sores</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Diphtheria</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Fever blisters</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pleurisy</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Venereal disease</p> <p><input type="checkbox"/> Whooping cough</p>
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Patient's Name _____ DOB _____ Date _____



CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 - 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result. I understand that I may ask for further explanation and risks of the procedure or treatment, as well as alternative procedures or methods. I give my permission and consent to the procedure or treatment.

Patient signature

Date