

**Dr. Darran J. Hamm / Viltalogy Chiropractic
Patient Intake Form**

Date _____

Please fill out and bring to your first visit.

First Name _____
Last Name _____
Nickname _____
Address _____
City _____
State _____
Zip _____
SS# _____ - _____ - _____
Gender Male Female
Date of Birth ____/____/____

Spouse's name _____

Home Phone (____) ____ - _____
Work Phone (____) ____ - _____
Fax (____) ____ - _____
Cell Phone (____) ____ - _____
Emergency Contact _____
(____) ____ - _____
Email _____
How did you hear about us? _____

Occupation _____

Employer _____
Work Address _____

Have you had a recent accident or injury?
Auto?
Work Related?

Yes No
 Yes No
 Yes No

Reason for visiting our office _____

Expectations: _____

Chiropractic Care:

Have you had prior chiropractic care? Yes No

Name of Doctor _____ Telephone _____

Results of prior care: Excellent Good Fair Poor

X-rays taken: YES NO If yes, when: _____ What areas: _____

Medical Doctor:

Medical Doctor's Name _____ Phone _____

Address _____

Date of last Appointment: _____ Date of last physical _____

Physical Therapist:

Name: _____ Phone: _____

Practice Location: _____

Diagnostic Procedures:

Please list X-ray, MRI, CT and ultrasound studies that been performed in the past .

Date: _____ Procedure: _____ Area Examined: _____ Results: _____

Release of information authorized: (for new patients)

I authorize Dr. Darran J. Hamm / Vitalogy Chiropractic to release any information or office records necessary to process insurance claims. This is to serve as a long-term authorization.

Patient Signature _____ **Date** _____

Other Information:

Lifestyle

- Smoking – packs / day _____
- Alcohol – drinks / day or week _____
- Coffee – cups / day _____
- Exercise – Minutes or hours / week _____
- Water – cups / day _____

Do you wake rested: YES NO

Do you feel overly fatigued during the course of a day: YES NO

Rate your Appetite: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Significant Falls and Accidents, list: _____

Have you ever been knocked unconscious: YES NO

If so for how long: _____

Please list any medications are you currently taking:

Please list any supplements:

Please list all accidents, injuries or surgeries to date:

_____ Year _____

_____ Year _____

_____ Year _____

Have you ever been hospitalized: YES NO

Reason: _____

Family History:

Relation

Diabetes:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Heart Disease:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Stroke:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Cancer:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Depression:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Other: _____			_____

Please list: _____

Signature: _____ **Date:** _____

Payment is expected at the time of visit

Name of person responsible for payment:

Are you insured? Yes No Company: _____

If yes, **please present you Health Insurance Card to staff at this time.**

I understand and agree that health and accident insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that Dr. Darran J. Hamm/ Vitalogy Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Darran J. Hamm / Vitalogy Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ **Date:** _____

Guardian or Spouse's Signature _____ **Date:** _____

PATIENT HISTORY FORM

Name: _____

Date: _____

Please check the appropriate box for any of the following symptoms that you have had within the last year.
C= Constant **F**=Frequent (weekly) **O**= Occasional (monthly/yearly)

C F O

Neurological

- allergy
- chills
- convulsions
- dizziness
- fevers
- headaches
- loss of sleep
- nervousness
- depression
- fainting
- fevers
- numbness
- sweats
- loss of weight
- tremors

Muscle & Joint

- arthritis
- bursitis
- foot trouble
- hernia
- low back pain
- neck pain
- neck stiffness
- mid shoulder pain

Respiratory

- chest pain
- chronic cough
- difficulty breathing
- spitting blood
- throat phlegm
- wheezing

Cardio-vascular

- rapid heart beats
- slow heart beats
- swelling of ankle
- hardening of arteries
- high blood pressure
- low blood pressure
- pain over heart
- poor circulation

C F O

Eyes, Ears, Nose & Throat

- colds
- deafness
- deafness
- asthma
- ear aches
- ear noises/ringing
- sinus infections
- enlarged glands
- sore throat
- eye pain
- failing vision
- far sighted
- near sighted
- nosebleeds

Gastro-Intestinal

- excessive hunger
- burping or gas
- liver trouble
- colitis
- colon trouble
- constipation
- diarrhea
- difficult digestion
- distension of abdomen
- stomach pain
- gall bladder trouble
- jaundice
- poor appetite
- nausea
- vomiting
- vomit blood

C F O

Skin

- boils
- bruises easily
- dryness
- itching
- skin rash
- varicose veins

Genito-Urinary

- frequent urination
- loss control urine
- kidney infection
- painful urination
- prostate trouble
- pus in urine
- smell of urine

Pain or numbness in:

- shoulders
- arms
- hands
- hips
- legs
- knees
- ankles
- feet
- painful tail bone
- sciatica
- swollen joints

For Women Only

- cramps
- heavy flow
- light flow
- irregular cycles
- painful cycle
- discharge
- sore breasts

Menopausal: YES NO

Last menstruation date: _____

Pregnant: YES NO

Due date: _____

