Today's Date: _____

VSC Wellness Center
Chiropractic • Acupuncture • Massage Therapy

Name: _____

Address: _____

City:_____St:_____Zip_____

Age: _____ Date of Birth: _____ Sex: M F

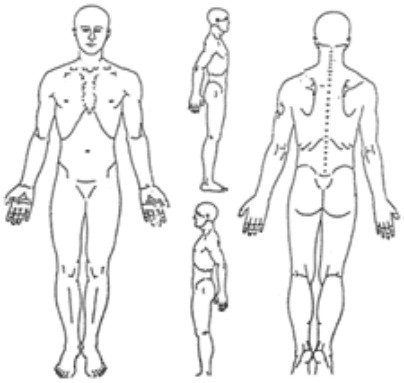
SSN#_____ Home Phone: _____

Cell Phone: _____Cell carrier: _____

How did you hear about our office: Drive-by, Phone book, Newspaper, Other Ad, Patient or Other Person- (please list so we may thank them)

_____

HEALTH INFORMATION: Please mark your areas of pain on the figures below.



Is your pain:

[ ] dull [ ] sharp [ ] stabbing [ ] achy

[ ] numb [ ] tingling [ ] throbbing [ ] tight

List the conditions that bring you to this office (Note if they are getting better or worse)

1_____

2_____

3_____

4_____

Have you had any other treatment for these problems? [ ] No [ ] Yes, please list:

_____

_____

Who is your primary care doctor:_____

*Female Patients: Is there a possibility you might be pregnant? No Yes

Date of Last Menstrual Period _____ Due Date_____ OB/GYN: _____

Where will you be delivering: St. Vincent's_____ Women's_____ Other_____

Birth order of baby: _____

Mark all that apply in the last 12 months

Review of systems: check any past or current symptoms

- ☐ recent fever/sweats
- ☐ unexplained weight loss/gain
- ☐ unexplained fatigue/weakness
- ☐ Change in vision
- ☐ difficulty hearing/ringing in ears
- ☐ hay fever/ allergies/ congestion
- ☐ trouble swallowing
- ☐ chest pain/discomfort
- ☐ palpitations
- ☐ shortness of breath on exertion
- ☐ cough/wheezing
- ☐ coughing up blood
- ☐ heartburn/reflux
- ☐ changes in bowel movements
- ☐ nausea/vomiting/ diarrhea
- ☐ pain in abdomen
- ☐ painful/bloody urination
- ☐ nighttime urination
- ☐ menstrual problems
- ☐ muscle/joint pain
- ☐ back pain
- ☐ rash
- ☐ change in skin
- ☐ Headache
- ☐ memory loss
- ☐ fainting
- ☐ dizziness
- ☐ anxiety/stress
- ☐ sleep problems
- ☐ unexplained lumps
- ☐ easy bruising/ bleeding
- ☐ cold/heat intolerance
- ☐ increased appetite
- ☐ increased thirst

Personal Medical history

- ☐ osteoporosis
- ☐ asthma/ lung disease
- ☐ high blood pressure
- ☐ diabetes: taking insulin Y N
- ☐ high cholesterol
- ☐ Heart disease (specify) _____
- ☐ thyroid problem
- ☐ kidney disease
- ☐ Seizures
- ☐ depression
- ☐ Cancer (specify)

other:

Surgical History: list all surgeries and dates

_____

_____

_____

Medications & Vitamins: list all prescription and non prescription

Family History:

indicate family member with any of the following:

alcoholism _____

cancer _____

heart disease _____

depression/ suicide _____

genetic disorders _____

diabetes _____

high cholesterol _____

high blood pressure _____

stroke _____

bleeding/clotting disorders _____

asthma/ COPD

other:

Social History

* **tobacco use**

cigarettes: Never Quit Date: _____

current smoker

packs/day ___ # of years

* **Alcohol use:** Yes No

drinks/week_____

* **Drug use**

recreational drugs Yes No

Needle use to inject drugs Yes No

* **Caffeine Intake**

None Coffee/tea/soda_____cups/day

* **Are you satisfied with your weight**_____

* **Rate your diet:** good fair poor

* **Exercise Regularly?** Yes No

what type: _____

how long: _____

how often: _____

* **Current Occupation** _____

* **Past Occupations** _____

* **Favorite Hobbies/Activities** _____

Current Primary Care Physician: _____

Printed Name: _____

Signature: _____ Date: _____

Consent to Share Confidential Medical Information

TO BE VALID, ALL LINES WITH AN ASTERIK (*) ON THIS FORM, MUST BE FILLED OUT COMPLETELY, including what information you are giving us permission to share. Place N/A on lines not applicable to your care.

*Patient's Legal Name: _____ *DOB_____

***I HEREBY AUTHORIZE VSC WELLNESS CENTER TO SHARE:**

☐ 1. Any of my medical information, including information about my medical diagnoses and imaging results
☐ 2. My appointment times, dates, and reasons for the visits and/ or billing issues
☐ 3. The following information (specify): _____

***WITH THE FOLLOWING PEOPLE:**

Full Name: _____ Relationship: _____

Authorized to share: 1 2 3 This authorization expires: Date: _____

Full Name: _____ Relationship: _____

Authorized to share: 1 2 3 This authorization expires: Date: _____

*I understand that my treatment, enrollment, or eligibility for benefits will not be conditioned on my signature ----------Initial_____

*I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law ---------- Initial_____

*I understand that I may cancel this consent at any time (by writing to VSC Wellness Center), but that canceling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my provider or my clinic to share my information with someone. If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

*Signature: _____ Date: _____

*Relationship to minor patient (if parent or legal guardian) : _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: _____ Date: _____

Acknowledgement of Policies and Procedures / Please Read and Sign

*Co-Pays are due at the time of service. Account balances must be below $150.00. ----------Initial_____

*It is required that you arrive 10 minutes before your scheduled muscle therapy appointment. If you are not here at that time your appointment may be given to another patient. ----------Initial_____

*We require a 24-hour notice to change or cancel appointment. A $25 fee for a 30 min appointment or a $30 fee for a 60 min appointment will be charged if you cancel or miss a muscle therapy appointment with less than 24-hour notice. No-Show/less than 24-hour notice more than 3 times will require prepayment at the time of scheduling for any future muscle therapy appointments. ----------Initial_____

*I have been given the opportunity to review the Financial Terms and Conditions ----------Initial_____

HIP & MEDICAID PATIENTS:

*If you miss three (3) scheduled muscle therapy appointments, you will not be able to schedule any muscle therapy appointments for a year. Any previously scheduled appointments will be cancelled after the third missed appointment----------Initial_____

Acknowledgement of Privacy Policy

*Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic, but please note private rooms are always available, upon request, for discussing your private health information---------- Initial_____

*This is to acknowledge that I have been given the opportunity to review VSC Wellness Center's Notice of Privacy Practices.
I acknowledge that I have read and understand the policies and procedures of VSC Wellness. I understand that I have the right to request a personal copy of this office's Notice of Privacy Practice.

*Sign _____ *Date _____