PATIENT INFORMATION

Patient Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

First Name_____ Middle Name_____ Nick Name_____

Last Name_____ Suffix_____ Previous Name_____

Address_____ City _____ State_____ Zip Code_____

Primary Phone_____ Secondary Phone_____ Cell Carrier (for text reminders)_____

Email (by providing my email address, I authorize my provider to contact me)_____

Contact Method: (Check one) ☐ Primary phone ☐ Secondary phone ☐ Email

Place of Employment_____ Work phone_____

Social Security Number_____-_____-_____

Referred by: (Check one) ☐ Patient ☐ Physician ☐ Internet ☐Other Name of person_____

Date of Birth: _____ / _____ / _____ Age_____ Gender: ☐ Male ☐ Female

Marital Status: (Check one) ☐ Single ☐ Married ☐ Other

Spouse Name & Phone number_____

Emergency Contact: Name_____ Relationship_____ Phone Number:_____

Insurance_____ Insured's Name_____

Insured's Date of Birth _____ / _____ / _____ Insured's Place of Employment_____

PATIENT CONDITION

Reason(s) for visit_____

Is this condition due to an accident ☐No ☐Yes: (circle one) Auto Work Home Date of occurrence:_____

If this is a work related injury, will you be opening a workman's compensation case? ☐Yes ☐No

When did your symptoms appear?_____

Is it constant pain? ☐Yes ☐No Does the pain come and go? ☐Yes ☐No

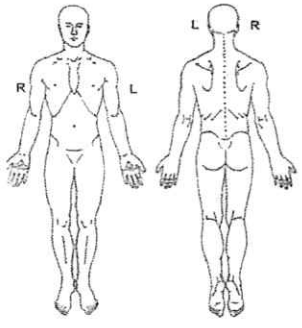
How often do you have this problem?_____ How long does the pain last?_____

Does the pain radiate? ☐Yes ☐No If Yes, please explain:_____

Does the pain interfere with: ☐Work ☐Sleep ☐Daily routine ☐Recreation

Activities or movements that are difficult to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Mark an "X" on the picture where you continue to have pain, numbness, or tingling:



Circle your pain on the scale below of 0-10:

At rest: No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

With activity: No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

What time of day is your current pain/problem worse?

☐Morning ☐Late in the day ☐Middle of the night ☐As the day progresses ☐N/A

Current pain/problem can be described as: (Check all that apply)

☐Electric ☐Sharp ☐Stabbing ☐Knife-like ☐Piercing ☐Shooting ☐Achy

☐Griping ☐Heavy ☐Cramp-like ☐Burning ☐Deep ☐Superficial ☐Stiffness (AM, PM, or both?)

☐Spasms ☐Tearing ☐N/A

What treatment have you already received for this condition?

☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Care ☐None

Name of other doctor(s)/provider(s) who have treated you for this condition and how: _____

PERSONAL HEALTH HISTORY & REVIEW

How many hours of sleep are you getting per night? ☐Less than 5 hours ☐6-8 hours ☐8-10 hours ☐10+ hours
How would you rate your sleep on the following scale? Wake up fully rested 1 2 3 4 5 6 7 8 9 10 No/Poor sleep
How many days a week do you exercise for 30 minutes or more? ☐ 0 ☐ 1-2 ☐ 3-4 ☐5-6 ☐ 7
How would you rate your intensity of your exercise? High Intensity 1 2 3 4 5 6 7 8 9 10 No Exercise
How would you rate your physical stress level? No Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed
How would you rate your emotional stress level? No Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed
List your major stressors: _____
What are your health goals?_____
In addition, talk to your provider about other areas which may be affecting your health, such as financial worries, social support, and alcohol/tobacco/drug use.

Are you currently under the care of any Healthcare Provider or Physician? ☐Yes ☐No
If yes, for what conditions?_____
Provider(s) Name(s):_____
_____

Has your doctor diagnosed you with Hypertension recently? ☒Yes ☐No Last blood pressure: _____ / _____
Has your doctor diagnosed you with Diabetes recently? ☐Yes ☐No
If yes, was your blood lab work test for Hemoglobin A1c > 9.0%? ☐Yes ☐No ☐Unknown
If yes, other comments regarding diabetes:_____
Have you had an x-ray or CT scan or MRI scan of your low back (lumbar spine) in the past 28 days? ☐Yes ☐No

Do you wear any of the following? ☐Heel Lifts ☐Innersoles ☐Arch Supports ☐Orthotics ☐Other_____
For how long? _____ Were they prescribed by a doctor? ☐Yes_____ ☐No
Have you seen a chiropractor in the past? ☐Yes ☐No Date of last visit: _____/____/_____
Were you satisfied with your care? ☐Yes ☐No Why? _____

Dates of last:

Chiropractic Exam		Prostate / PSA	
Cholesterol		Mammogram	
MRI scan		Pap Smear	
CT scan		Colonoscopy	
Spine x-ray		Stool check for blood	
Bone density scan			

Childhood Illnesses:

☐ ADD
☐ Atopic dermatitis
☐ Allergies / Hay fever
☐ Anemia
☐ Asthma
☐ Bed wetting
☐ Cerebral palsy
☐ Chicken Pox
☐ COVID
☐ Crohn's / Colitis
☐ Depression
☐ Diabetes
☐ Ear infections
☐ Fetal drug exposure
☐ Headaches
☐ Hepatitis
☐ HIV
☐ Measles
☐ Mumps
☐ Psoriasis
☐ Rash
☐ Scoliosis
☐ Seizures
☐ Sickle Cell
☐ Spina Bifida
☐ Other:

Immunizations:

☐ All recommended vaccines
☐ Adenovirus
☐ DTaP(diphtheria,tetanus,pertussis)
☐ Hepatitis B
☐ Influenza
☐ MMR (measles, mumps, rubella)
☐ Rotavirus
☐ Varivax (chicken pox)
☐ Not vaccinated
☐ COVID _____
☐ Haemophilus B
☐ Gardasil
☐ IPV (polio)
☐ Pneumoccocal
☐ Tetanus
☐ Other:_____

REVIEW OF SYSTEMS

Please indicate if you have any of the following by checking the box.

Cardiovascular	☐ none ☐ high blood pressure ☐ low blood pressure ☐ heart problem ☐ heart murmur ☐ claudication (leg pain and ache) ☐ orthopnea (difficulty breathing laying down) ☐ palpitations ☐ ulcers ☐ shortness of breath with exertion ☐ paroxysmal nocturnal dyspnea ☐ varicose veins
Constitutional	☐ none ☐ daytime drowsiness ☐ fever ☐ night sweats ☐ chills ☐ fatigue ☐ weight gain/loss ☐ loss of appetite
Ears, Nose, & Throat	☐ none ☐ fainting ☐ history of head injury ☐ runny nose ☐ nosebleeds ☐ dizziness ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infection ☐ ear pain ☐ ear discharge ☐ headaches ☐ hearing loss ☐ nasal congestion
Eyes/Vision	☐ none ☐ cataracts ☐ double vision ☐ eye problems ☐ itching ☐ photophobia ☐ blindness ☐ blind spots ☐ tearing ☐ wear contacts/glasses
Female	☐ none/NA ☐ birth control ☐ breast lump/pain ☐ burning urination ☐ frequent urination ☐ abnormal vaginal bleeding ☐ hormone therapy ☐ irregular menstruation ☐ vaginal discharge ☐ cramps ☐ urine retention/incontinence I … ☐ am currently pregnant ☐ am NOT currently pregnant I … ☐ currently have menses ☐ DO NOT currently have menses My menses … ☐ are regular ☐ are NOT regular Age of first menses: _____ Age when menopause began: _____ Date of last menstrual period: _____/_____/_____ If you have been pregnant in the past, please fill in the appropriate information below. _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies _____ Number of c-sections _____ Number of vaginal deliveries _____ Number of miscarriages _____ Number of terminated pregnancies
Gastrointestinal	☐ none ☐ belching ☐ black/tarry stool ☐ constipation ☐ diarrhea ☐ difficulty swallowing ☐ abdominal pain ☐ heartburn ☐ hemorrhoids ☐ indigestion ☐ jaundice ☐ ulcers ☐ abnormal stool ☐ rectal bleeding ☐ loss of bowel control
Hematologic	☐ none ☐ bleeding ☐ blood transfusion ☐ fatigue ☐ ☐ ☐ anemia ☐ blood clotting ☐ bruising easily ☐ lymph node swelling
Male	☐ none/NA ☐ burning urination ☐ frequent urination ☐ prostate problems ☐ ED (erectile dysfunction) ☐ hesitancy/dribbling ☐ urine retention/incontinence
Nervous System	☐ none ☐ headache ☐ limb weakness ☐ loss of consciousness ☐ loss of memory ☐ dizziness ☐ numbness ☐ seizures ☐ sleep disturbances ☐ slurred speech ☐ stroke ☐ facial weakness ☐ stress ☐ unsteadiness of gait/loss of balance
Psychological	☐ none ☐ bipolar disorder ☐ depression ☐ confusion ☐ convulsions ☐ insomnia ☐ anxiety ☐ behavioral changes ☐ loss or change of appetite ☐ memory loss ☐ mood change
Respiratory	☐ none ☐ cough ☐ shortness of breath ☐ wheezing ☐ asthma ☐ coughing up blood ☐ sputum production
Sexual Health	Do you have any concerns about your sexual health? ☐ yes ☐ no Are you or have you ever been a victim of domestic or sexual abuse? ☐ yes ☐ no
Skin	☐ none ☐ change in nail texture ☐ change in skin color ☐ hair loss ☐ hives ☐ itching ☐ history of skin disorders ☐ numbness ☐ rash ☐ skin lesions/ulcers ☐ varicosities
Teeth/Oral	☐ metal amalgam fillings ☐ root canal(s) ☐ wisdom teeth removed ☐ cavitations

Adult Illnesses:

- ☐ ADD
- ☐ Allergies / Hay fever
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Asthma
- ☐ Atopic dermatitis/eczema
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Chicken Pox
- ☐ COVID
- ☐ Crohn's / Colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ Cystic Kidney disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eye problems
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis
- ☐ HIV
- ☐ High blood pressure
- ☐ Influenza pneumonia
- ☐ Liver disease
- ☐ Lung disease
- ☐ Lupus Erythema
- ☐ Multiple Sclerosis
- ☐ Parkinson disease
- ☐ Pleural effusion, unspecified
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Psychiatric condition
- ☐ Scoliosis
- ☐ Seizures
- ☐ Shingles
- ☐ STDs/STIs
- ☐ Suicide attempt(s)
- ☐ Thyroid problems
- ☐ Vertigo
- ☐ Other: _____

Injuries (list date next to injury):

- ☐ back injury
- ☐ broken bones
- ☐ disability (ies)
- ☐ fall (severe)
- ☐ fracture
- ☐ head injury
- ☐ industrial accident
- ☐ joint injury
- ☐ laceration (severe)
- ☐ motor vehicle accident
- ☐ soft tissue injury
- ☐ other: _____

Surgeries:

Date	Procedure & Description	
		Inpatient / Outpatient
		Inpatient / Outpatient
		Inpatient / Outpatient
		Inpatient / Outpatient
		Inpatient / Outpatient

Please check the appropriate response. If you are not sure, check the "?" box.

NO	YES	?	
☐	☐	☐	Do you have a have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does the pain you have improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?
☐	☐	☐	Prolonged use of corticosteroids (such as with organ transplant)?
☐	☐	☐	IV drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppression medication and/or conditions?
☐	☐	☐	Are you currently or have you used blood thinners?
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person > 50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Acute onset urinary tract retention or overflow incontinence (wet underwear)?
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
☐	☐	☐	Saddle anesthesia (numbness in the groin region)?
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)?

ALLERGIES

Are you allergic to any medication(s)? ☐Yes ☐No
If yes, which medications?

_____

Are you allergic to any of the following?
☐Bee stings ☐Latex ☐Peanuts ☐Shellfish
☐Dairy ☐Mold ☐Pollen ☐Wheat ☐Eggs
☐Nuts ☐Gluten ☐Other_____

SMOKING HISTORY

Do you currently smoke tobacco of any kind?
☐Yes ☐Former Smoker ☐Never been a smoker
Do you currently vape? ☐Yes ☐No ☐Sometimes
If yes, how often do you smoke?
☐Current every day smoker
☐Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
0 1 2 3 4 5 6 7 8 9 10
No interest Very interested

MEDICATIONS

List current medication, including frequency and dosage. Please include over-the-counter medications.
If there are no current medications, check here ☐
(Patient may bring a list of medications and attach it to this form, if needed)

MEDICATION NAME	QUANTITY / DOSAGE	FREQUENCY	START DATE

SOCIAL HISTORY

Work Activity: What is your job description? _____
What work do you do most of the day at work? ☐Sitting ☐Standing ☐Light labor ☐Heavy labor ☐Other
What job did you do most of your life? _____
How would you describe the physical stress level at work? _____
Level of education completed: ☐High school ☐College ☐Trade school

Nutrition / Diet:

Blood type? ☐O ☐A ☐AB ☐B ☐Do not know
Rate your appetite (circle one): Normal appetite 1 2 3 4 5 6 7 8 9 10 Eat nothing
Do you drink water? ☐Yes ☐No Filtered water? ☐Yes ☐No
Alcohol use: Now? ☐Yes ☐No Amount/Weekly_____
In the past? ☐Yes ☐No Amount/Weekly_____
How many coffee caffeine drinks do you drink a day? Cups _____ None ☐
How many soda caffeine drinks do you drink a day? Cups _____ None ☐

List current vitamins/minerals/herbs: (Please include quantity/dosage & frequency.)

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Relation	Age (now or at death)			Serious illness/Cause of death
Father		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Paternal grandfather		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Paternal grandmother		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Mother		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Maternal grandfather		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Maternal grandmother		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Brother(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Sister(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Son(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Daughter(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	

All the answers I have given are correct and to the best of my knowledge. I agree to continue my care at this time.

_____

Patient Signature Date

_____

Signature of Parent or Legal Guardian Relationship

Van Engen Chiropractic and Health Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, (Patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Van Engen Chiropractic and Health Clinic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received and maintained by the Practice.

_____ Date

_____ Signature

_____ Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ _____ [patient's name] receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner (check all that applies) :

- ☐ Personally ☐ Mail ☐ Phone Follow Up
- ☐ Other: _____

_____ Date

_____ Signature

_____ Print Name of Chiropractor

Van Engen Chiropractic and Health Center

Name of Practice

Van Engen Chiropractic and Health Center

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Van Engen Chirorpractic Clinics' ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, clinical education, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of healthcare services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Chiropractor or the Practice has acted in reliance on this consent.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority