

Welcome to Health In Focus

54 W. Twin Oaks Terrace, Suite 9, South Burlington, VT 05403

Date: _____

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

Address: _____ Marital Status: M S D W CU

City: _____ Name of Spouse/Partner: _____

State: _____ Zip Code: _____ Employer: _____

Social Security #: _____ Type of Work: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Do you have children? Y N Emergency Contact: _____

If so, what age(s)? _____ Emergency Contact Tel#: _____

What is your Height: _____ Weight: _____

Who may we thank for referring you today: _____

Previous Chiropractic Care: None / Approximate Date of Last Visit: _____

Name of Recent Chiropractor: _____

Name of Primary Care Physician _____ Phone Number () _____

Who is Responsible for This Account? You and (circle): Family / Health Insurance / Workers' Comp / Auto Insurance

Insurance Company Name: _____ Policy ID #: _____

Policy Holder's Name: _____ Date of Birth: _____

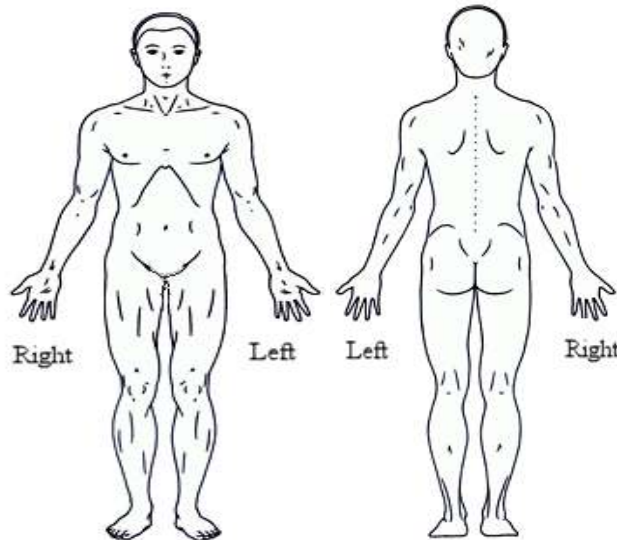
Address: _____

Employer: _____

Do you have a Healthcare Savings Account (HSA)? Y N

Is your problem caused by? Auto Accident / Worker's Compensation / Neither

Indicate on the drawings below where you have pain/symptoms:



Please circle-

How often do you experience your symptoms?

Constantly (76%-100% of the time)

Occasionally (26-50% of the time)

Frequently (51-75% of the time)

Intermittently (1-25% of the time)

How would you describe the type of pain (circle)?

Sharp

Numb

Dull

Tingling

Diffuse

Achy

Burning

Shooting

Sharp with Movement

Shooting with Movement

Stabbing with Movement

Electric like with Movement

Stiff

Other: _____

How are your symptoms changing with time?

Getting Worse

Staying the Same

Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your pain/problem?

0 1 2 3 4 5 6 7 8 9 10 (circle one)

How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

How much has the problem interfered with your social activities?

Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem?

Chiropractor (how many visits this year?) _____ Primary Care Physician Massage Therapist

Physical Therapy (how many visits this year?) _____ Orthopedist No One

Other: _____

How long have you had this problem?

How do you think this problem began?

Do you consider this problem severe?

What aggravates your problem?

What alleviates your problem?

What concerns you the most about your problem; what does it prevent you from doing?

How would you rate your overall health?

Excellent Very Good Good Fair Poor

What type of exercise do you do?

Strenuous Moderate Light None

Please list any immediate family members with any of the following:

Rheumatoid Arthritis _____ Diabetes _____ Osteoarthritis _____
Heart Problems _____ Cancer _____ Back Pain _____

Please list any current medications, vitamins, or herbs you are taking and what they are for:

Medications/Vitamins/Herbs Approximate Date Started Amount Taken per Day Condition taking for

Medications/Vitamins/Herbs	Approximate Date Started	Amount Taken per Day	Condition taking for

Please list any allergies you may have: _____

Have you experienced significant trauma in the past? Yes No

If yes, what happened? _____

Surgery/Operations: Appendectomy Gall Bladder Hernia Back Surgery Broken Bones Vascular Surgery C-Section

Other: _____

Accidents or Falls: _____

Hospitalization (Other Than Above): _____

Other Information Pertinent To Your Health:

Have you had any x-rays, MRI scans, or CT scans? Yes No

If yes, what area(s) of the body? _____

In which facility were they taken? FAHC Vermont Radiologist Other _____

Please check any condition that you have or have had:

Please check any that you use:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	INTAKE <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Alcohol <input type="checkbox"/> Cigarettes
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Pleurisy	
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Disorders	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lumbago	
<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Eczema	

Check Any of the Following You Have Experienced In the Past 6 Months:

<p>MUSCULO-SKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Neck Pain <input type="checkbox"/> Arm Pain <input type="checkbox"/> Joint Pain/Stiffness <input type="checkbox"/> Walking Problems <input type="checkbox"/> Difficult Chewing/Clicking Jaw <input type="checkbox"/> General Stiffness <p>NERVOUS SYSTEM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervous <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion/Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Convulsions <input type="checkbox"/> Cold/Tingling Extremities <input type="checkbox"/> Stress <p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Allergies <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Fever <input type="checkbox"/> Headaches 	<p>C-V-R</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Short Breath <input type="checkbox"/> Blood Pressure Problems <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Problems <input type="checkbox"/> Lung Problems/Congestion <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Stroke <p>GASTRO-INTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor/Excessive Appetite <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequent Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver Problems <input type="checkbox"/> Gall Bladder Problems <input type="checkbox"/> Weight Trouble <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Gas/Bloating After Meals <input type="checkbox"/> Heartburn <input type="checkbox"/> Black/Bloody Stool <input type="checkbox"/> Colitis <p>GENITO-URINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder Trouble <input type="checkbox"/> Painful/Excessive Urination <input type="checkbox"/> Discolored Urine 	<p>EENT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vision Problems <input type="checkbox"/> Dental Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Ear Aches <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Stuffed Nose <input type="checkbox"/> Losing Sense of Smell <input type="checkbox"/> Losing Sense of Taste <p>MALE/FEMALE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Menstrual Irregularity <input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Vaginal Pain/Infection <input type="checkbox"/> Breast Pain/Lump <input type="checkbox"/> Prostate/Sexual Dysfunction <input type="checkbox"/> Other Problems <p>FEMALES ONLY</p> <p>When was your last period? _____</p> <p>Are you pregnant? Y N</p>
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Patient's Signature: _____ Doctor's Signature: _____