Van Wyk Chiropractic Center Patient Information

Date: _____

Name: _____ Age: _____ Birthday: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Cell Phone Provider: _____

Home Phone: _____Work Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouses Name: _____ Spouses Occupation: _____

Children's Names and Ages: _____

Emergency Contact: _____ Phone Number: _____

How Did You Hear About Us? □ Referral □ Website □ Social Media □ Insurance

Whom Can We Thank for Referring You to Our Office? _____

Have You Ever Had Chiropractic Care Before? _____ Date of Last Chiropractic Visit: _____

What Type of Chiropractic Adjustment Did You Have? □ Manual □ Instrument □ Both

What Are Your Current Health Problems That You'd Like Dr. Van Wyk to Help You With?

_____

_____

_____

Pain or Problem Started On: _____

How Did This Occur? _____

Have You Have This Problem Before? _____ If Yes, When Was the Last Time? _____

Is Your Problem: □ Constant □ Intermittent □ Getting Worse □ Improving □ Acute □ Chronic

Is Your Problem Worse in the Morning or Evening? □ Morning □ Evening

Do You Have: □ Pain □ Numbness □ Tingling □ Burning □ Aches □ Stiffness □ Swelling □ Cramps

If You Have Pain, Is It: □ Sharp □ Dull □ Throbbing □ Burning □ Constant □ Intermittent

Is the Intensity of Your Pain: □ Mild □ Moderate □ Severe □ Intolerable

If You Have Radiating Pain, Is It Moving Into Your Arms or Legs? □ Arm(s) □ Leg(s)

On A Scale Of 1-10 (*1 least, 10 most*), Please Rate the Severity Of Your Pain: _____

What Activities Aggravate Your Condition/Pain? _____

What Activities Relieve Your Condition/Pain? _____

Are You Having Trouble: □ Sitting □ Standing □ Lying Down □ Walking □ Bending

Are You Having Trouble With: □ Work □ Sleep □ Daily Activities □ Exercise □ Hobbies

Is Your Problem Affecting Your: □ Productivity □ Stress □ Attitude/Mood □ Quality of Life

Are You Currently Receiving Care from Other Health Professionals? □ Yes □ No

If yes, list what you are being seen for and the medical diagnosis that you have: _____

_____

_____

Check all the following symptoms that you currently have or have had in the last year:

□ Headaches	□ Dizziness	□ Loss of Smell	□ Fatigue
□ Neck Pain	□ Stomach Problems	□ Loss of Taste	□ Ears Ring
□ Difficulty Sleeping	□ Neck Stiffness	□ Light Bothers Eyes	□ Constipation
□ Back Pain	□ Pins & Needles in Arms	□ Loss of Memory	□ Diarrhea
□ Nervousness	□ Pins & Needles in Legs	□ Cold Sweats	□ Fainting
□ Irritability	□ Numbness in Fingers	□ Muscle Tension	□ Fever
□ Chest Pains	□ Numbness in Toes	□ Constipation	□ Acid Reflux
□ Shoulder Pain	□ Shortness of Breath	□ Loss of Balance	□ Hands Cold
□ Tension	□ Night Sweats	□ Buzzing in Ears	□ Feet Cold

Check all the following conditions that you currently have or have had in the past:

□ Cancer	□ Heart Disease	□ Stroke	□ Seizures
□ Diabetes	□ Depression	□ Anxiety	□ Arthritis
□ Eczema	□ Thyroid	□ Epilepsy	□ Neuropathy

Surgeries – List any spinal surgeries or other surgeries:

Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

Fractures – List any spinal fractures or other fractures:

Fracture: _____ Date: _____
Fracture: _____ Date: _____
Fracture: _____ Date: _____

Allergies – List any allergies that you have: □ Food □ Environmental □ Medication

Major Illness – List any major illnesses you've had and the date you had them:

Illness: _____ Date: _____
Illness: _____ Date: _____
Illness: _____ Date: _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	□	□	□	□	□
Mother's Side	□	□	□	□	□

Do you smoke? □ Never □ Former Smoker □ Current/Everyday □ Current/Some Days

Height: _____ Weight: _____ Blood Pressure: _____

Van Wyk Chiropractic Center
Informed Consent, Privacy Policy, Financial Policy

Informed Consent

When a patient seeks chiropractic care in our office it is important that they understand the type of services we provide. Chiropractic care is a separate service from the practice of medicine. We do not prescribe drugs, do injections, or diagnose medical conditions. If we ever feel you have a health situation that may require medical attention, we will advise you to consult with your medical doctor.

Chiropractic is a science, art, and philosophy that concerns itself with the health of the spine, musculoskeletal system, and the nervous system. Chiropractic treatment, called the chiropractic adjustment, is a specific type of joint manipulation, using either the doctor's hands or an instrument. The goal is to restore health and function to the joint(s) of the spine and their surrounding tissues and reduce interference to the nervous system. Doing this reduces or eliminates pain, stress, and tension and improves health and quality of life.

Chiropractic care has been proven to be very safe and effective and is one of the most popular health choices available. Although rare, it is possible to have side effects from treatment. Some patients may experience temporary soreness or pain after their first few treatments. Other side effects, while rare, can include muscle spasm, muscle or ligament strain, bruising, rib fracture, headache, dizziness, flushing, and stroke. The medical research on strokes and chiropractic shows that it is very rare, and the risk of stroke is very small for both chiropractic and medical treatment.

There are risks to not receiving chiropractic care when needed. These include pain, unhealthy spinal joints and other joints of the body, muscle tension and tightness, degenerative changes, adhesions, and scar tissue. These can further reduce back and neck health, mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult and cause a decrease in health and quality of life.

Privacy Policy

As per HIPPA law, your health information will be kept private. If you are using insurance, by signing this form you agree to allow us to share your medical records from our office with your insurance provider if they request them. Any requests for your medical records from attorneys, other doctor's offices, or any other entities will require your additional signature at the time they are requested.

Financial Policy

You are responsible for the payment of all services rendered to you at the time of service. If you are using insurance, you are legally required to pay your co-payment each visit. You are also responsible for the payment of any services you receive that are not covered by your insurance.

I acknowledge that I have received, reviewed, and agree to the Informed Consent, Privacy Policy, and Financial Policy of this office. I have read and fully understand all the above statements. I agree to receive care at Van Wyk Chiropractic Center on this basis.

_____

Your Signature Date