Bella Vita Chiropractic

DATE: _____

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University Place, WA 98466
Phone: (360) 990-2842
www.BellaVitaChiro.com

Personal Information

Name _____ Nickname "_____"

☐ Male ☐ Female Age _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

☐ Single ☐ Married ☐ Partner ☐ Widowed Email Address _____

Occupation _____ Employer _____

How did you hear about us? _____

Your Health Profile

1. **Why This Form Is Important…**

We want to make sure you receive the best care possible to allow your body to function at its highest levels.

Our goals are to:

- Address the concerns that brought you into our office.
- Offer you the opportunity of improved health, wellness and quality of life in the future.

2. Please briefly describe your mail health concern, please include the effect is has had on your life:

_____

_____

3. **Health Concerns** List health concerns in Order of Importance	**Severity** 1 = MILD 10 = UNBEARABLE	**Date This Episode Started**	**If Ongoing, Date Of Last Episode**	**Was There An Injury**	**Is This Constant Or Periodic**
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Knife Like

Does the pain radiate/travel anywhere? ☐ No ☐ Yes – Please Explain Below

_____

Since the problem started, is it: ☐ Getting Better ☐ Getting Worse ☐ About The Same

What makes it better? _____

What makes it worse? _____

What have you done that hasn't helped? _____

Is this condition interfering with your:

☐ WORK ☐ LEISURE ☐ SLEEP ☐ EXERCISE ☐ ATTITUDE ☐ HOBBIES ☐ OTHER _____

Have you thought of and/or felt the need to make any "positive" changes due to this condition?

(For example: eating better, less alcohol/drugs, more water, stress reduction, etc.) If yes, what: _____

_____

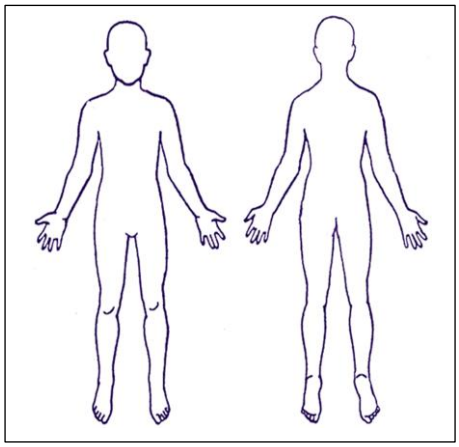
☐ I DO ☐ I DO NOT Have a family history of this or similar symptoms (please explain)

_____

4. Show Us Where It Hurts: Please mark the area of injury or discomfort.

Numbness: **NNN**
Pins & Needles: **PPP**
Burning: **BBB**
Aching: **AAA**
Stabbing: **SSS**

Circle any areas of pain not detailed with a symbol.



Front Back

Other doctors seen for this condition: ☐ Chiropractor ☐ Medical Doctor ☐ Other: _____

1. Name/Address: _____
   Date: _____ Diagnosis: _____
2. Name/Address: _____
   Date: _____ Diagnosis: _____

General History

Please check all symptoms/conditions you have ever had. Please indicate "Current" with a C and "Past" with a P.

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Problems	☐ Urinary Problems
☐ Anxiety	☐ Pins & Needles in Arms	☐ Back Pain	☐ Loss of Balance	☐ Menstrual Pain
☐ Dizziness	☐ Diabetes	☐ Sciatica	☐ Nervousness	☐ Breast Lumps
☐ Fatigue	☐ Depression	☐ Fever	☐ Ringing in Ears	☐ Hot Flashes
☐ Diarrhea	☐ Constipation	☐ Ulcers	☐ Cold Hands	☐ Menstrual Irregularity
☐ Allergies	☐ High Blood Pressure	☐ Tension	☐ Cold Feet	☐ Sleep Problems
☐ Irritability	☐ Mood Swings	☐ Heartburn	☐ Muscle Cramps	☐ Difficulty Breathing
☐ Stroke	☐ Diabetes	☐ Fibroids	☐ Heart Attack	☐ Cold Sweats

List any medications and/or supplements you are taking and why: (Prescription & Non Prescription) _____

_____

_____

Please List All Surgeries Below:

1. Type: _____ Date: _____ Is This a Recurring Problem? ☐ Yes ☐ No
2. Type: _____ Date: _____ Is This a Recurring Problem? ☐ Yes ☐ No
3. Type: _____ Date: _____ Is This a Recurring Problem? ☐ Yes ☐ No

Please List All Accidents and/or Injuries (Auto, Work Related, Sports, etc.) Even If They Don't Seem Relevant:

1. Type: _____ Date: _____ Hospitalized? ☐ Yes ☐ No
2. Type: _____ Date: _____ Hospitalized? ☐ Yes ☐ No

3. Type: _____ Date: _____ Hospitalized? ☐ Yes ☐ No

4. Type: _____ Date: _____ Hospitalized? ☐ Yes ☐ No

Have you ever had x-rays taken? ☐ Yes ☐ No If yes: When: _____ Where: _____

Diagnosis: _____

Please List Your Top 3 Stresses In Each Category:

1. Physical Stress (Falls & Accidents, Posture, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-Chemical Stress (Alcohol, Unhealthy Foods, Drugs, Missed Meals, etc.)
   a. _____
   b. _____
   c. _____
3. Emotional Stress (Work, Divorce, Finances, Death, etc.)
   a. _____
   b. _____
   c. _____

The Early Years – Birth to 17 Years Old

Research is showing that many of the health challenges we face as adults started in the developmental years, often as early as birth. Please answer the following questions as honestly and accurately as possible.

	YES	NO	UNSURE
1. Did you have any serious childhood illnesses?	☐	☐	☐
2. Did you have any serious falls as a child?	☐	☐	☐
3. Did you have any serious accidents as a child?	☐	☐	☐
4. Did you play youth sports?	☐	☐	☐
5. Did you take/use any drugs? (Prescription or Recreational)	☐	☐	☐
6. Did you have any surgeries?	☐	☐	☐
7. Did you suffer any other traumas, physical or emotional?	☐	☐	☐
8. Did you have any prolonged use of antibiotics or inhalers?	☐	☐	☐
9. Were you vaccinated?	☐	☐	☐
10. Did you receive regular chiropractic care?	☐	☐	☐
11. Did you received the flu shot?	☐	☐	☐

Comments: _____

_____

_____

The Adult Years – 18 Years Old to Present

	YES	NO
1. Do/Did you smoke?	☐	☐
2. Do/Did you drink alcohol (more than socially)?	☐	☐
3. Have you been in an accident (car, work, fall, etc)?	☐	☐
4. Have you had any surgeries?	☐	☐
5. Do/Did you play adult sports?	☐	☐

6. Do/Did you play extreme sports? ☐ ☐

On a scale of 1-10, 1 **being very poor, 10 being excellent**, rate your:

Diet:	1	2	3	4	5	6	7	8	9	10
Exercise:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10
Mind Set:	1	2	3	4	5	6	7	8	9	10
Overall Health:	1	2	3	4	5	6	7	8	9	10

One a scale of 1-10, **I being none, 10 being extreme**, rate your emotional stress levels:

Occupational:	1	2	3	4	5	6	7	8	9	10
Personal:	1	2	3	4	5	6	7	8	9	10

Family History

Are any of your family members effected by any of the following conditions? Please explain

☐ Cancer _____ ☐ Arthritis _____

☐ Diabetes _____ ☐ Heart Attack _____

☐ Stroke _____ ☐ Other _____

At our office, we are interested in the health & well-being of your family and loved ones, in addition to you. Please list their names and the health concerns they have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Other: _____

Closing Notes

	YES	NO
1. If there is a need for dietary changes, would you like to be informed?	☐	☐
2. If there is a need for specific exercises, would you like to be informed?	☐	☐
3. If there is a need for support in the stress dimension of health, would you like to be informed?	☐	☐
4. Females Only: is there a chance you may be pregnant?	☐	☐

I consent to a professional chiropractic examination and to any radiographic (x-ray) examination the doctor recommends. I understand that any fee for service(s) rendered is due at the time of service and cannot be deferred to a later date.

Printed Name: _____

Signature: _____ Date: _____

Please fill out pages 5 – 6 only if you were involved in a work or auto accident.

Auto or Work Related Accident

About You

Name: _____ Today's Date: _____

Auto Related Accident

Date of Accident: _____ Time of Accident: _____ ☐ a.m. ☐ p.m. # of people in vehicle ___

Where did the accident take place? _____

What did your vehicle impact? ☐ Another vehicle ☐ Other: _____

	YES	NO	
1. Did the police come to the accident site?	☐	☐	
2. Was there a police report filed?	☐	☐	
3. Was a traffic violation issued?	☐	☐	If you, to who? _____
4. Was there any witnesses?	☐	☐	
5. Were you surprised by the impact?	☐	☐	
6. Were you wearing your seatbelt?	☐	☐	
7. Did your vehicle have airbags?	☐	☐	
a. If yes, did they inflate?	☐	☐	
8. Did you lose consciousness?	☐	☐	
9. Did you receive any medical attention?	☐	☐	

a. How long after the accident? _____

b. From who was care received? _____

10. About your vehicle:
    a. Year / Make / Model: _____
    b. Estimated speed you were traveling: _____
    c. Where was your vehicle impacted: ☐ Front ☐ Rear ☐ Driver's Side ☐ Passenger's Side
    d. During impact, were you facing: ☐ Right ☐ Left ☐ Forward ☐ Backwards
    e. In relation to the base of your skull, where was the headrest?
    ☐ Above ☐ Below ☐ At the base of skull
    f. Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
    If yes, please explain: _____
11. About the other vehicle:
    a. Year / Make / Model: _____
    b. Estimated speed they were traveling: _____
12. Please describe the accident: _____

_____

_____

Work Related Accident

Date of Accident: _____ Time of Accident: _____ ☐ a.m. ☐ p.m.

1. Please describe the events immediately bore and during the accident: _____

_____

_____

2. Location / Address of accident: _____
3. Were there witnesses? ☐ Yes ☐ No

4. Did you report the accident to your employer? ☐ Yes ☐ No
5. What recommendations did your employer make immediately after you reported the accident? _____
   _____
6. Have you had this type of accident before? ☐ Yes ☐ No
7. To your knowledge, has this type of accident happened in your workplace before? ☐ Yes ☐ No
8. Is your job physically stressful? ☐ Yes ☐ No
9. Is your job mentally stressful? ☐ Yes ☐ No

After The Injury

1. Describe how you felt right after the accident: _____
2. Were x-rays taken? ☐ Yes ☐ No
3. Was medication prescribed? ☐ Yes ☐ No
4. Have you worked since the accident? ☐ Yes ☐ No
5. Are your activities restricted? ☐ Yes ☐ No
6. Check the symptoms that have resulted from the accident:

☐ Dizziness	☐ Sleep Problems	☐ Low Back Pain	☐ Mid Back Pain	☐ Fatigue
☐ Tension	☐ Memory Loss	☐ Headaches	☐ Blurred Vision	☐ Leg Pain
☐ Nausea	☐ Arm / Shoulder Pain	☐ Ringing in Ears	☐ Chest Pain	☐ Numbness
☐ Neck Pain	☐ Irritability	☐ Upset Stomach	☐ Body Stiffness	☐ Other

7. Is your condition: ☐ Getting Better ☐ Getting Worse ☐ The Same ☐ Varied
8. Please rate your comfort levels when performing these activities:

	Comfortable	Uncomfortable	Painful	N/A
Laying on back	☐	☐	☐	☐
Laying on side	☐	☐	☐	☐
Laying on stomach	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Stretching	☐	☐	☐	☐
Sex	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Running	☐	☐	☐	☐
Sports	☐	☐	☐	☐
Working	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Pulling	☐	☐	☐	☐

Additional Insurance – Auto or Workers Compensation

Type of Insurance: _____ Insurance Co. Name: _____
Adjustors Name: _____ Adjustors Phone #: _____
Claim Number: _____ Do you have PIP Coverage? ☐ Yes ☐ No
Insured's Name: _____ Insured's DOB: _____