VarioHealth, PLLC

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE NOTIFY CLINIC

PATIENT INFORMATION

Today's Date: _____

Name:_____

Age:_____DOB:_____Sex: ▫ M ▫ F

Address:_____

Home:_____Work:_____Cell: _____

Cell Carrier:_____ e-mail: _____

I consent to receive appointment reminders and office communications by text, e-mail, or telephone____ (initials)

Your Employer: _____

Occupation: _____

▫ Married ▫ Single ▫ Divorced ▫ Separated ▫ Other

Name of Spouse or Nearest Relative: _____

Phone Work:_____Cell: _____

Insurance Information

Name of Carrier: _____

_____

Name of Insured:_____

Insureds DOB: _____

Subscriber ID:_____

Group Number:_____

I certify that I or my dependents have insurance coverage with the above listed company and assign directly to VarioHealth, PLLC all insurance benefits. I understand that I am financially responsible for all charges not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient: _____

Referred to this office by: ▫ Website ▫ Yellow Pages ▫ Friend/Family Member Name: _____

Payment for Services will be by: ▫ Cash ▫ Check ▫ Credit Card ▫ Health Insurance

Are you covered by more than one insurance company? ▫ Yes ▫ No Name: _____

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**

Please indicate which conditions have been experienced by the above by marking appropriate boxes.

S M F		S M F		S M F	
▫ ▫ ▫	anemia	▫ ▫ ▫	arthritis	▫ ▫ ▫	asthma
▫ ▫ ▫	back pain	▫ ▫ ▫	bladder trouble	▫ ▫ ▫	bone fracture
▫ ▫ ▫	cancer	▫ ▫ ▫	chest pain	▫ ▫ ▫	concussion
▫ ▫ ▫	convulsions	▫ ▫ ▫	diabetes	▫ ▫ ▫	indigestion
▫ ▫ ▫	dislocated joins	▫ ▫ ▫	epilepsy	▫ ▫ ▫	German measles
▫ ▫ ▫	headaches	▫ ▫ ▫	heart trouble	▫ ▫ ▫	reproductive disorders
▫ ▫ ▫	high blood pressure	▫ ▫ ▫	kidney disorder	▫ ▫ ▫	bowel control loss
▫ ▫ ▫	menstrual cramps	▫ ▫ ▫	multiple sclerosis	▫ ▫ ▫	muscular dystrophy
▫ ▫ ▫	neck pain	▫ ▫ ▫	nervousness	▫ ▫ ▫	numbness
▫ ▫ ▫	polio	▫ ▫ ▫	poor circulation	▫ ▫ ▫	hepatitis
▫ ▫ ▫	rheumatic fever	▫ ▫ ▫	rheumatism	▫ ▫ ▫	scarlet fever
▫ ▫ ▫	serious injury	▫ ▫ ▫	sinus trouble	▫ ▫ ▫	tuberculosis

Have you been treated by a physician for any health condition in the last year? ▫ Yes ▫ No

Describe Condition:_____ Date of Last Physical Exam: _____

Describe the Treatment: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

▫ CHECK HERE IF YOU HAVE NO SYMPTOMS AND ARE HERE FOR WELLNESS CARE

Area/Body Part	Intensity					Frequency			
1._____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
2._____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
3._____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
4._____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant
5._____	Minimal	Slight	Moderate	Marked	Severe	Intermittent	Occasional	Frequent	Constant

If you are experiencing pain, is it: ▫ Dull ▫ Sharp ▫ Stabbing ▫ Achy ▫ Tingling/Numb ▫__

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

Symptoms are worse in: ▫ Morning ▫ Afternoon ▫ Night

Aggravated by: ▫ Sitting ▫ Standing ▫ Laying ▫ Bending ▫ Coughing ▫ Lifting ▫ Walking ▫ Turning your head

▫ Other (please describe) _____

Please list any activities you avoid or cannot do due to this condition: _____

What makes your symptoms better: ▫ Rest ▫ Ice ▫ Heat ▫ Medication_____ ▫ Nothing

WHEN AND HOW DID YOUR SYMPTOMS BEGIN: _____

▫ Gradual Onset ▫ Job Accident ▫ Car Accident ▫ Illness ▫ Unknown ▫ Other:_____

Have you had this problem before? ▫ Yes ▫ No When:_____ How was it treated?_____

Name of doctor previously seen for this condition: _____

Have you ever been to a chiropractor before? ▫ Yes ▫ No **Was it for this problem?** ▫ Yes ▫ No

Please list all medications you are currently taking: _____

Are you pregnant? ▫ Yes ▫ No

SURGICAL HISTORY ▫ NONE

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

ACCIDENT HISTORY ▫ NONE

▫ Job ▫ Auto ▫ Other 1._____Date:_____

▫ Job ▫ Auto ▫ Other 2._____Date:_____

▫ Job ▫ Auto ▫ Other 3._____Date:_____

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING

▫ fainting	▫ fatigue	▫ loss of balance	▫ numb fingers	▫ acid reflux	▫ numbness in toes
▫ PMS	▫ insomnia	▫ upset stomach	▫ tingling legs	▫ ear infections	▫ tingling arms
▫ constipation	▫ stiff neck	▫ shortness of breath	▫ baby with colic	▫ ringing in ears	▫ muscle jerking
▫ decreased athletic performance					

The information I have provided is accurate to the best of my recollection and is intended to provide VarioHealth, PLLC with necessary information in order to diagnose my condition(s) and to determine the appropriate treatment. By providing this information, it is my intent to be examined, diagnosed and treated by VarioHealth, PLLC and for no other purpose.

Patient's Signature:_____ Date: _____

Print Name:_____