**Confidential Health Information**

**Grove Chiropractic**

**Dr. Tyler Vorst, DC**

212 W. Sycamore St.

Columbus Grove, OH, 45830

419-659-2271

www.Grovedc.com

Please allow our staff to photocopy your driver’s license and

insurance details. All information you supply is confidential.

We comply with all federal privacy standards. Please print clearly.

Today’s Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Whom may we thank for referring you? No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Last Name Your Social Security Number Birth Date (MM/DD/YYYY) Age

Gender

Your First Name Your Middle Name/Initial Male Female Race

Address Marital Status Ethnicity

City State Zip Children Preferred Language

Home Phone Cell Phone Cell Carrier

Email Address Would You Like Text Message Reminders? Yes No

Emergency Contact Emergency Contact’s Phone

Your Occupation

Your Employer Work Phone

Address May we contact you at work?

Yes No

City State Zip Preferred Method of contact?

Home Phone Cell Phone

Work Phone Email

Primary Care Provider’s Name

Insurance Carrier Policy Number

Insured’s Last Name Birth Date (MM/DD/YYYY) Who carries this policy?

Self Spouse Parent

Insured’s First Name Insured’s Middle Name/Initial

Insured’s Employer

Address

City State Zip Employer’s Phone

1. **The symptom(s) that have prompted me to seek care today include**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **And are the result of**: An accident or injury

Work Auto Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A worsening long-term problem

An interest in: Wellness Nutrition

1. **Onset** (When did you first **4. Duration and Timing** (When did it start and how often do you feel it?)

notice your symptoms?) Constant Comes and goes. How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Intensity** (How bad are your symptoms)

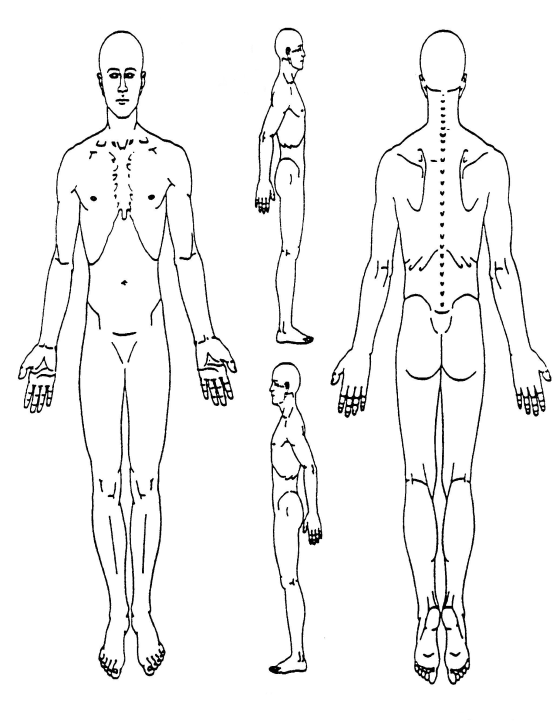
0 10

1 2 3 4 5 6 7 8 9

**6. Location** (Where does it hurt?) **7**. **Quality of symptoms** (What does it feel like)

Mark the area(s) on the illustration.

* Numbness
* Stiffness
* Dull
* Aching
* Cramps
* Nagging
* Sharp
* Burning
* Shooting
* Throbbing
* Stabbing
* Other\_\_\_\_\_\_\_

 **8**. **Radiation** (Does it affect other areas of your body?

To what areas does the pain radiate, shoot, or travel to?)

start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Aggravating or relieving factors** (What makes it better or worse

such as time of day, movements, certain activities, etc.)

What tends to worsen

the problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tends to lessen

the problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Prior interventions** (What have you done to relieve symptoms?)

Prescription Medication Surgery Ice

Over-the-counter drugs Acupuncture Heat

Homeopathic remedies Chiropractic Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical therapy Massage

**11. What else should Grove Chiropractic know about your current condition?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**12. How does your current condition interfere with your:**

**Work or career**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recreational activities**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Household Responsibilities**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Relationships**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Review of Systems**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition you’ve **Had** or currently **Have** and initial to the right.

1. **Musculoskeletal**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Osteoporosis Arthritis Scoliosis Neck pain Back pain Hip disorders

Knee injuries Foot/Ankle pain Shoulder pain Elbow/wrist pain TMJ issues Poor posture Initials\_\_\_\_\_

**B. Neurological**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Anxiety Depression Headache Dizziness Pins & Numbness

Needles Initials\_\_\_\_\_

**C. Cardiovascular**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

High blood Low blood High Poor Angina Excessive

pressure pressure cholesterol circulation bruising Initials\_\_\_\_\_

**D. Respiratory**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Asthma Apnea Emphysema Hay fever Shortness Pneumonia

of breathe Initials\_\_\_\_\_

**E. Digestive**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Anorexia/ Ulcer Food allergies Heartburn Constipation Diarrhea

Bulimia Initials\_\_\_\_\_

**F. Sensory**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Blurred vision Ringing in Hearing loss Chronic ear Loss of smell Loss of taste

ears infection Initials\_\_\_\_\_

**G. Skin**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Skin cancer Psoriasis Eczema Acne Hair loss Rash

Initials\_\_\_\_\_

**H. Endocrine**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Thyroid issues Immune Hypoglycemia Frequent Swollen glands Low energy

disorders infections Initials\_\_\_\_\_

**I. Genitourinary**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Kidney stones Infertility Bedwetting Prostate issues Erectile PMS symptoms

dysfunction Initials\_\_\_\_\_

**J.** **Constitutional**

**Had Have Had Have Had Have Had Have Had Have Had Have None**

Fainting Low libido Poor appetite Fatigue Sudden weight Weakness

gain/loss Initials\_\_\_\_\_

**Past Personal, Family, and Social History**

Please identify your past health history, including accidents, injuries, illnesses, and treatments.

**14. Illnesses**

Please write in any illness you have had in the past or have right now.

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**15. Operations** **(Both inpatient and outpatient procedures)**

Please write in any operations you have had in the past, and include the approximate year.

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**16. Injuries**

Please write in any injuries or motor vehicle accidents you have had in the past, and include the approximate year.

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**17. Medications**

Please write in any medications or over-the-counter drugs you are currently taking. (If you have a medication list with you, please give it to the receptionist and skip to the next question)

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**18. Family History**

Some health issues are hereditary. Tell Grove Chiropractic about the health of your immediate family members (heart disease, diabetes, cancer, etc.).

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**19. Social History** (Tell Grove Chiropractic about your health habits and stress levels.)

Alcohol use Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee use Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercising Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain relievers Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soft Drinks Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Water intake Daily Weekly How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**20**. **Activities of Daily Living** (How does this condition currently interfere with your life and ability to function?)

No effect Mild effect Moderate effect Severe effect No effect Mild effect Moderate effect Severe effect

Sitting-------------------------- Grocery shopping----------

Rising out of a chair------ Household chores----------

Standing--------------------- Lifting objects----------------

Walking ---------------------- Reaching overhead--------

Lying down------------------ Showering or bathing-----

Bending over--------------- Dressing myself-------------

Climbing stairs------------- Love life------------------------

Using a computer--------- Getting to sleep-------------

Getting in/out of car------- Staying asleep---------------

Driving------------------------- Concentrating----------------

Looking over shoulder--- Exercising---------------------

Caring for family------------ Yard work----------------------

**21. What is the major stressor in your life?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 22. How much sleep do you average per night?\_\_\_\_\_Hours**

**23**. **Describe your typical eating habits:**  Skip breakfast Two meals a day Three meals a day Snacking between meals

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial you agreement.

Initials\_\_\_\_\_

Initials\_\_\_\_\_

Initials\_\_\_\_\_

Initials\_\_\_\_\_

Initials\_\_\_\_\_

**I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation and muscle adhesion. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

**I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

**I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.**

**I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

**To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

**If the patient is a minor child, print child’s full name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Signature Date (MM/DD/YYYY)*

Doctors Initials

Dr. Tyler Vorst, DC