Vickers AK Chiropractic

Please Print Clearly In Ink

Name _____ Date _____
Last First Middle

Address _____
Number Street City State Zip Code

Telephone _____ How did you hear about us? Person (name?) _____

Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated Sign (which?) _____

Sex: ☐ Male ☐ Female Children: Boys ____ Girls ____ Yellow Pages (which?) _____

Patient's Information

Nickname _____
Date of Birth _____ Age _____
Social Security # _____
Occupation _____
Employer _____
Employer address _____
_____
Employer Phone # _____

Person Responsible For Payment (Guarantor)

Name _____
Date of Birth _____ Age _____
Social Security # _____
Occupation _____
Employer _____
Employer address _____
_____
Employer Phone # _____

Spouse Information Name _____ Date of Birth _____ Age ____
Employer _____ Social Security # _____
Employer Address _____ Employer Phone # _____

In Case Of Emergency (Relative Not At Your Same Address): Name _____
Address _____ Phone# _____

Consent to Treatment of Minor Child I hereby authorize Dr. Joel B. Vickers to administer Chiropractic care as he deems necessary to my child Signed _____ (Parent or Guardian)

Witnessed _____ (Staff member)

Name of person who filled out this form *if other than patient* _____

Have you ever been seen by any other chiropractors? YES / NO

Name _____ Name _____

Address _____ Address _____

Date _____ For? _____ Date _____ For? _____

Have you seen a Medical Doctor or an Osteopath for this problem? YES / NO

Name _____ Name _____

Address _____ Address _____

Date _____ What tests were taken? _____ Date _____ What tests were taken? _____

_____

Have you been x-rayed in the last 6 months? YES / NO What type of x-ray was taken? _____

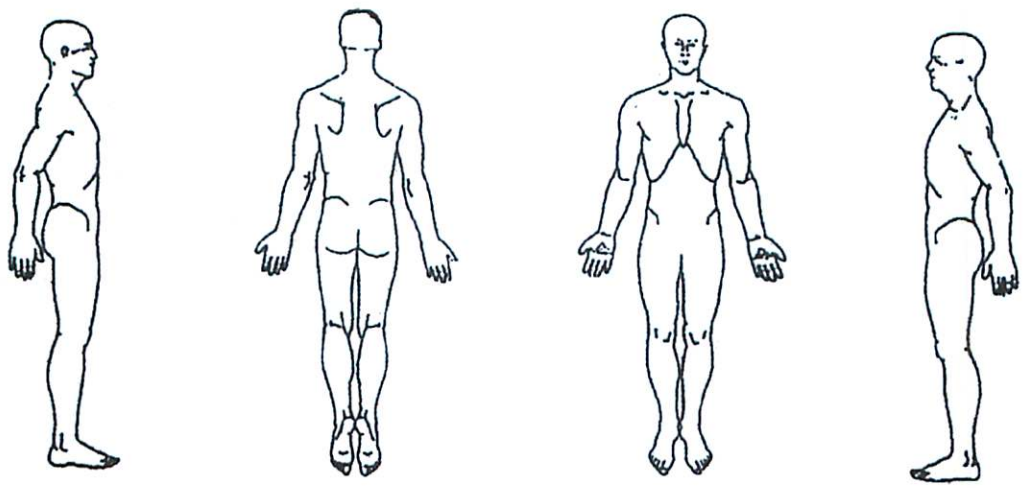
Where was the x-ray taken? (hospital, clinic etc.) _____

Why did you come to this office? In other words, please list your *major concerns* in the order of their importance

_____

_____

Please mark on the diagram the area/s of your discomfort



What is the date of the first occurrence of this trouble? _____

Is this accident related? YES / NO

How did this injury occur? _____

_____

_____

_____

What methods have you tried to alleviate your pain/discomfort? _____

What medications are you taking? _____

_____

What vitamins, minerals or other supplements are you currently taking? _____

_____

Which of these factors affect your trouble? (please check *all* boxes)

	No Effect	Better	Worse		No Effect	Better	Worse
Any Movement				Lying Down			
Sitting Down				During the Night			
While Sitting				Turning in Bed			
Standing Up				While Resting			
While Standing				First Thing in the Morning			
Bending Forward				During time of Intense Activity			
Bending Backward				Toward End of the Day			
Bending Right				Before Meals			
Bending Left				After Meals			
While Running				Immediately After Meals			
While Walking				2-4 Hours After Meals			

PLEASE CIRCLE: MOTHER: LIVING / DECEASED FATHER: LIVING / DECEASED

PLEASE ANSWER THE FOLLOWING FOR EACH FAMILY MEMBER

	FATHER	MOTHER	SISTER	BROTHER	DAUGHTER	SON
Diabetes						
Cancer						
TB						
Heart Disease						
High Blood Pressure						
Low Blood Pressure						
Hypoglycemia						

Other _____

List all past and current diseases for yourself, including childhood. Include dates.

_____ _____

_____ _____

_____ _____

List all car accidents and all major falls or injuries, even including childhood. Include dates!

_____ _____

_____ _____

_____ _____

_____ _____

List all types of surgeries, including childhood. Include dates.

_____

_____

_____ _____

List all types of dental work including fillings, crowns, braces, root canals, etc. Include dates.

_____

_____ _____

I am (CIRCLE ONE): RIGHT HANDED / LEFT HANDED / BOTH

Do you have any sexually related problems? YES / NO Explain: _____

Number of times you urinate during the DAY____ NIGHT____ (Please approximate)

How often do you have a bowel movement?_____ per Day / Week (circle one)

Do you have sufficient energy for your normal activities? YES / NO

Are you under emotional stress? YES / NO Regarding what? _____

_____

Do you exercise? YES / NO

What type of exercise/s and how often in a week? _____

_____ _____ _____

Female Patients:

Date of last menstrual period _____How often do you menstruate? _____

Number of days from beginning of period until beginning of next period? _____

List any menstrual discomfort _____

_____

Do you gain weight before or during your menstrual cycle? YES / NO How much weight on average? _____

List any menopause symptoms you are experiencing _____

_____

When did symptoms start? _____

PERSONAL HISTORY

How much weight have you GAINED _____ and/or LOST_____ in the past 5 years?

Do you diet? YES / NO How often in a year? _____

Do you sleep well at night? ☐ YES ☐ NO

How many hours, generally? _____

Do you take naps? ☐ YES ☐ NO

Do you have difficulty getting to sleep? ☐ YES ☐ NO

Do you wake up tired? ☐ YES ☐ NO

Do you tire easily during the day? ☐ YES ☐ NO

Are you usually exhausted during the day? ☐ YES ☐ NO

Have mental confusion or forgetfulness? ☐ YES ☐ NO

Are you usually tense or nervous? ☐ YES ☐ NO

Do you worry easily? ☐ YES ☐ NO

Is your disposition usually good? ☐ YES ☐ NO

Ever had a nervous breakdown? ☐ YES ☐ NO

Ever advised to consult a psychologist? ☐ YES ☐ NO

Ever advised to consult a psychiatrist? ☐ YES ☐ NO

Do you faint or become unconscious? ☐ YES ☐ NO

Have dizzy spells? ☐ YES ☐ NO

Ever had convulsions? ☐ YES ☐ NO

Does your heart ever beat rapidly and you feel trembly when not exercising? ☐ YES ☐ NO

Short of breath upon exertion? ☐ YES ☐ NO

Do you ever experience a pain or a tight feeling in your chest or heart region? ☐ YES ☐ NO

Does your heart ever race or pound? ☐ YES ☐ NO

Do you have any heart symptoms? ☐ YES ☐ NO

Explain: _____

_____

Ever diagnosed with stomach ulcers? ☐ YES ☐ NO

Other stomach trouble? ☐ YES ☐ NO

Explain: _____

Do you ever have indigestion? ☐ YES ☐ NO

If YES: ☐ During meals ☐ After eating anything

☐ After meals ☐ Bedtime

☐ Occasionally ☐ All of the time

Diagnosed with colitis? ☐ YES ☐ NO

Bleeding from any part of your body? ☐ YES ☐ NO

Where? _____

Nose bleeding in childhood? ☐ YES ☐ NO

Do you bruise easily? ☐ YES ☐ NO

Losing vision in either/both eyes? ☐ YES ☐ NO

Do you have double vision? ☐ YES ☐ NO

Do you wear glasses or contacts? ☐ YES ☐ NO

How often does your vision or your prescription change? _____

Eyes extremely sensitive to light? ☐ YES ☐ NO

Do you have cold hands or feet? ☐ YES ☐ NO

Do your hands or feet get numb or tingle? ☐ YES ☐ NO

Do you frequently have a stiff neck? ☐ YES ☐ NO

Do you get headaches? ☐ YES ☐ NO

One side of head hurt worse than other? ☐ YES ☐ NO

Can you tell when a headache is coming? ☐ YES ☐ NO

Do you have vomiting with a headache? ☐ YES ☐ NO

Nausea with a headache? ☐ YES ☐ NO

What age did headaches first begin? _____

Are your headaches more apt to occur on certain days of the week or month? ☐ YES ☐ NO

Do you know of any cause for your headaches such as foods, worry, menstrual cycle, weather etc.?

Explain: _____ ☐ YES ☐ NO

Is the onset of the headache ☐ Sudden ☐ Gradual

Does the pain stop ☐ Suddenly ☐ Gradually

How often do you have headaches?_____ per wk / mo

How long do they last? _____ hours / days

Have different kinds of headaches? ▯ YES ▯ NO

Explain: _____

_____

Any instability or unsteadiness associated with your posture while (circle answer/s) standing, walking running or reclining? Explain: _____

_____

Problems with (circle one) LEFT foot or RIGHT foot or BOTH feet?

Explain: _____

Problems with ankle stability? ▯ YES ▯ NO

Do you have rheumatism? ▯ YES ▯ NO

Neuritis (inflamation of a nerve)? ▯ YES ▯ NO

Muscle cramps anywhere in your body? ▯ YES ▯ NO

Explain: _____

Do your lower limbs swell? ▯ YES ▯ NO

Do you perspire freely? ▯ YES ▯ NO

Any hearing impairment? ▯ YES ▯ NO

If yes: ▯ Hearing Loss ▯ Ear noise

▯ Discharge ▯ Itching

Do your teeth decay easily? ▯ YES ▯ NO

Any teeth problems now? ▯ YES ▯ NO

Explain: _____

Gums bleed when teeth are brushed? ▯ YES ▯ NO

Any trouble with your hair or nails? ▯ YES ▯ NO

Do you use tobacco? ▯ YES ▯ NO

Explain: _____

Do you ever have diarrhea? ▯ YES ▯ NO

constipation? ▯ YES ▯ NO

Take medication for your bowels? ▯ YES ▯ NO

How often? _____ What? _____

Is there any hay fever, allergy, or asthma in your family? ▯ YES ▯ NO

Do you use any of the following?

▯ Alcohol	▯ Daily ▯ Weekly ▯ Monthly
▯ Coffee	▯ Daily ▯ Weekly ▯ Monthly
▯ Pop/Soda	▯ Daily ▯ Weekly ▯ Monthly
▯ Lipton style tea	▯ Daily ▯ Weekly ▯ Monthly
▯ Dairy Products	▯ Daily ▯ Weekly ▯ Monthly
▯ Sweets/Desserts	▯ Daily ▯ Weekly ▯ Monthly
▯ Hydrogenated Fats	▯ Margarine ▯ Shortening

Are there any other health issues not addressed in these forms you would like Dr. Vickers to know about?

_____

_____

What do you expect to accomplish by receiving Applied Kinesiology based treatments from Dr. Vickers?

_____

_____

To the best of my knowledge, the answers given are true and accurate.

Signature _____

Date_____

1 South Waverly Rd Suite 3 **Vickers AK Chiropractic, P.C.** Holland, MI 49423
(616) 738-1200 **Dr. Joel B. Vickers** Fax (616) 738-1242

APPOINTMENT CANCELLATION POLICY

Dr. Vickers has deemed it necessary to require a 24 hour notice to change or cancel an appointment. This has become necessary for the following two reasons:

-A patient who does not show up for a scheduled appointment or who cancels on short notice denies other patients the opportunity to schedule an appointment. This becomes important to those patients who are in severe pain and require immediate treatment.

-This is Dr. Vickers source of income which supports his family, his staff and his practice. If we do not have sufficient notice to replace the cancelled appointment, Dr. Vickers loses valuable income.

We also understand unavoidable last minute emergencies, but these are really quite rare for most people. Failure to provide a 24- hour notice of cancellation can incur a $45 office charge.

If you do not give sufficient notice on more than one occurrence, we will require you to prepay your next visit.

We sincerely thank you for your understanding and cooperation in this important matter and look forward to a healthy relationship with you and your family.

Signature: _____

Printed Name: _____

Date: _____

PATIENT CONSENT FORM

By signing this form, you are granting consent to Joel B. Vickers, D.C. to use and disclose your protected health information for the purposes of treatment and payment. Our Notice of Privacy Practices has more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have the right to revoke this consent in writing, except to the extent we may have already used or disclosed your protected health information in reliance on your consent.

Signature:_____

Printed Name:_____

Date:_____