



NEW ADULT PATIENT HISTORY INTAKE

To our new patients: *Welcome* to Vital Force Upper Cervical Clinic LLC. You've made an excellent decision by choosing us for your *healthcare*. To help us establish you with our practice, please provide us with your complete health history. If you have any questions or are having trouble reading this form, please let us know.

First Name _____ M.I. _____ Last Name _____
Birth Date ____/____/____ Age ____ Gender (M F) Marital Status (S M W D) Spouse Name _____
Address _____ City/State/Zip _____
Best Phone (____) _____ type of phone (cell home work) Other Phone (____) _____
Email _____ Employer _____ Occupation _____
Emergency Contact _____ Relationship _____ Phone (____) _____
How Did You Find Us? _____ Referred By _____

Please describe what's going on and what result you'd like to achieve:

In your opinion, what how would you rate your overall level of health? (1-10) _____

Do you have any other health goals/concerns? _____

Have you been seen or treated by another doctor for any health condition in the last year? Yes No

Describe condition and outcome _____

Are you on any medications? Yes No What kind? _____

Do you take any supplements? Yes No What kind? _____

Personal Health History (please check the box of any of the following that are relevant to your history)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussion | <input type="checkbox"/> Head Trauma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Sleeping Trouble | <input type="checkbox"/> Car Accident (s) | <input type="checkbox"/> Ringing Ears | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Balance Trouble | <input type="checkbox"/> Other _____ |

Personal Health Habits

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Smoker (daily, occasionally) | <input type="checkbox"/> Poor Diet | <input type="checkbox"/> Using artificial sweeteners | <input type="checkbox"/> Yearly flu shot |
| <input type="checkbox"/> Alcohol (daily, socially) | <input type="checkbox"/> Stomach Sleeper | <input type="checkbox"/> No exercise program | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Caffeine (daily, occasionally) | <input type="checkbox"/> Recreational Drugs | | |

Would you like to receive a complementary gift certificate to a friend or family member to be examined by Dr. Bagley to be used within the next 3 weeks? Yes No

For Women Only: Are you pregnant? Yes No Date of Last period: _____ Menstrual Cramps? Yes No

This history record has been designed to facilitate our clients' continuity of care at Vital Force Upper Cervical Clinic LLC. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so. I hereby authorize the doctors at Vital Force to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient (Guardian signature who filled out the history)

Date