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 ***health***care. 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)

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

Personal Health Habits

☐ Smoker (daily, occasionally)	☐ Poor Diet	☐ Using artificial sweeteners	☐ Yearly flu shot
☐ Alcohol (daily, socially)	☐ Stomach Sleeper	☐ No exercise program	☐ Stress
☐ Caffeine (daily, occasionally)	☐ Recreational Drugs		

Would you like to receive a complementary gift certificate to a friend of 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