



(703) -879-5144 fax (703) 879-5860

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### PATIENT INFORMATION

(Provide copy of insurance card & photo ID)

Name (last, first) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F NB

Height \_\_\_\_\_ Weight \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Marital Status \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

Relationship To Contact \_\_\_\_\_

Primary Doctor Name \_\_\_\_\_

Primary Doctor Phone \_\_\_\_\_

I authorize release of healthcare documents to

Primary Doctor: Yes / No

How did you hear about us? \_\_\_\_\_

\_\_\_\_\_

### CURRENT HEALTH CONDITIONS

Primary Complaint \_\_\_\_\_

Secondary Complaint \_\_\_\_\_

Cause of Complaint

Auto Accident Fall Work Injury

Sport Injury Other \_\_\_\_\_

Pain Level NOW

No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Pain level at its WORST

No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

When did this condition begin? \_\_\_\_\_

What percentage of the day does it bother you?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

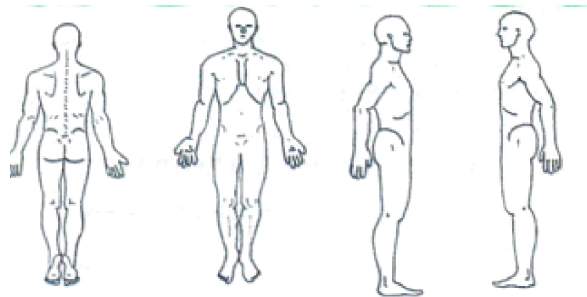
When does it bother you the most

AM MIDDAY PM NIGHT ALL DAY

What worsens the condition? \_\_\_\_\_

What offers relief? \_\_\_\_\_

Affecting Daily/ Recreational Activities? Yes / No



Indicate areas where you feel discomfort/pain

Practitioners Notes (Administrative Only)

## Symptoms

### General

Headaches Fever Chills Night Sweats Fainting Dizziness  
Convulsions Loss of Sleep Fatigue Nervousness Weight Loss  
Arm/Hand Numb Arm/Hand Pain Leg/Foot Pain Neuralgia

### Muscle & Joints

Weakness Twitching Stiff Neck Backache Swollen Joints  
Tremors Tailbone Mid/Upper Back Pain Hernia SPinal  
Curvature Metal/Electric Implant

### Gastro-Intestinal

Poor Appetite Poor Digestion Excessive Hunger Belching/Gas  
Nausea Vomiting Stomach Pain Constipation Diarrhea  
Colon Trouble Hemorrhoids Liver Trouble Jaundice  
GallBladder Problems Rectal Bleeding

### Cardiovascular

Rapid Heart Beat Slow Heart Beat High Blood Pressure  
Low Blood Pressure Pain Over Heart Prior Heart Condition  
Ankle Swelling Poor Circulation Varicose Veins  
Stroke History Pacemaker

### Eye/Ear/Nose/Throat

Poor vision Crossed Eyes Pain in Eyes Deafness Earache  
Ear noises Ear Discharge Nasal Obstruction Sore Throat  
Hoarseness Asthma/Wheezing Frequent Cold Thyroid  
Problems Tonsillitis Sinus Trouble Hearing Aids

### Skin Allergies

Skin Eruptions Itching Bruises/Bruise Easily Dryness Boils  
Sensitive Skin Hives Eczema Hay Fever Rash Open Cuts  
Hair Piece Bleeding Disorder

### Respiratory

Chronic Cough Spitting Blood Spitting Phlegm  
Chest Pain Difficulty Breathing

### Genito-Urinary

Frequent Urination Painful Urination Blood In Urine  
Kidney Infection Kidney Stones Bed Wetting  
Urine Control Problems Prostate Issues

## CURRENT MEDICATIONS

Name Dosage / Frequency

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

Do you smoke or Drink? How Often?

\_\_\_\_\_

## Experienced Diseases

Appendicitis	Anemia	Heart Disease
Arthritis	Pneumonia	Measles
Goiter	Epilepsy	Bell's Palsy
Mumps	Influenza	Lumbago
Polio	Chicken Pox	Pleurisy
Tuberculosis	Diabetes	Alcoholism
Eczema	Whooping Cough	Hypoglycemia
Cancer	Hepatitis A B C	HIV AIDS
Osteoporosis	MS	Lupus
Lou Gehrig's Disease	Other: _____	

## Women Only

Are you pregnant? Y / N Planning on it? Y / N

When are you due? \_\_\_\_\_

When was your last period? \_\_\_\_\_

Last Pap Smear Date \_\_\_\_\_

Painful Periods Excessive Flow Irregular Cycles Hot Flashes  
Cramps/Backache Miscarriage Vaginal Discharge Menopause

## HEALTH HISTORY

Surgery? Major Accidents? Hospitalizations? Allergies?

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

## Family Health History

Diabetes Heart Kidney Cancer Back  
Mother  
Father Siblings  
Other Family Events \_\_\_\_\_

I have read and reviewed the following policies by Vitalite  
Chiropractic (VC) on their website or they were provided to me.

X HIPAA Notice of Privacy Practices  
X Financial | Cancellation | Reschedule Policy  
X Informed Consent To Treat

I hereby sign all the mentioned documents and attest that all the  
included information is true and correct to the best of knowledge. I  
choose to decline receipt of my clinical summary after every visit.

\_\_\_\_\_  
Patient Name / Date

\_\_\_\_\_  
Patient Signature

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