



Patients Personal Records
(Confidential)

Today's Date: _____

Full Name: _____ Nickname: _____

Legal Guardian (if under 18): _____

Complete Address: _____

Email Address: _____

Phone #: Business: _____ Home: _____

Cell: _____

Sex: ____M ____F Age: _____ DOB: _____

Emergency Contact: _____ Phone: _____

Marital Status: (*optional, circle one*) Single, Married, Divorced, Separated, Widowed, Partnered

Occupation: _____

Place of Employment: _____

Job Description: (ex: heavy lifting, computer/sitting all day, stressful etc.) _____

Recreational Habits and Hobbies (how often do you work out and what): _____

Referred By: _____

Present Chief Complaint

Reason for visit today: _____

When did your problem begin? _____

Explain HOW: _____

Have you had this problem previously? _____ If so when? _____

What concerns you most about your condition? _____

Does it bother your work, sleep, other? _____

Is it getting worse? ____ Yes ____ No

Have you been given a diagnosis for you condition? _____

Have you had treatment for this condition? ____ Yes ____ No

WHEN, if treated? _____ Results? _____

Treated by: (D.C., M.D., other) _____

List all medications that you are presently taking: birth control, over-the-counter meds (tums, aspirin..., and how often) *Please use additional paper if more room is needed.*

List all vitamins, herbs, etc. that you are presently taking on a regular basis

List any other Doctors you are currently seeing and why: _____

Related Health History

Some health conditions are a result of our environment in the way we live and work.

List any electrical items you may use at home or work. (electric blankets, heating pads, computers, diagnostic machinery, etc.)

List any chemicals you use around the home or at work. (Paint, varnish, photography chemicals, fertilizers, pesticide sprays, asbestos, etc.)

Do you have any mercury fillings? If so, how long have you had them? _____

Family Health History

Some health conditions are a result of hereditary weakness. Information about the immediate family members, brothers, sisters, parents, or grandparents will give us a better understanding of your total health picture. Please use additional paper if more room is needed.

Relationship

Present & Past Health Problems

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Past Medical History– List all surgeries, pregnancies, illnesses, childhood diseases, etc.
Please use additional paper if more room is needed.

Social History– Example: smoking, drinking, alcohol abuse, substance abuse, exercising...How much or how long? *Please use additional paper if more room is needed.*

In order to better serve your health goals please indicate the extent of the care you desire from the Vreeland Clinic.

- Wellness care to optimize my health and reduce my probability of future illness including, but not limited to my present complaint.
- Relief of my present symptoms only. This may mean that the actual cause of the these symptoms may be left untreated.