GEORGIA VITALITY CHIROPRACTIC

Welcome Back Health Form

Please print clearly and fill in completely

Print Name _____ **Email** _____

Current Street Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Date of Birth** _____

Do you have insurance that you believe may cover part of your chiropractic care?

Please Check ✓ **Yes** ❑ **No** ❑ Name or type of insurance: _____

Health History

Explain current reason or health issues for returning for your chiropractic care: _____

_____

_____

Describe any additional other health issues: _____

_____

Are you under the care of any other doctor? Yes❑ No❑ If Yes, explain conditions being treated for:

_____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History

Your Current Occupation _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History

Have you ever been to another Chiropractor since you last visit here? Yes❑ No❑

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ If yes why? _____

Rate Your Overall Health

Our goal is to help you achieve and maintain optimal health. To better help you with this we need to understand how you view your overall health. Please **circle** what you consider to be your current level of health.

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

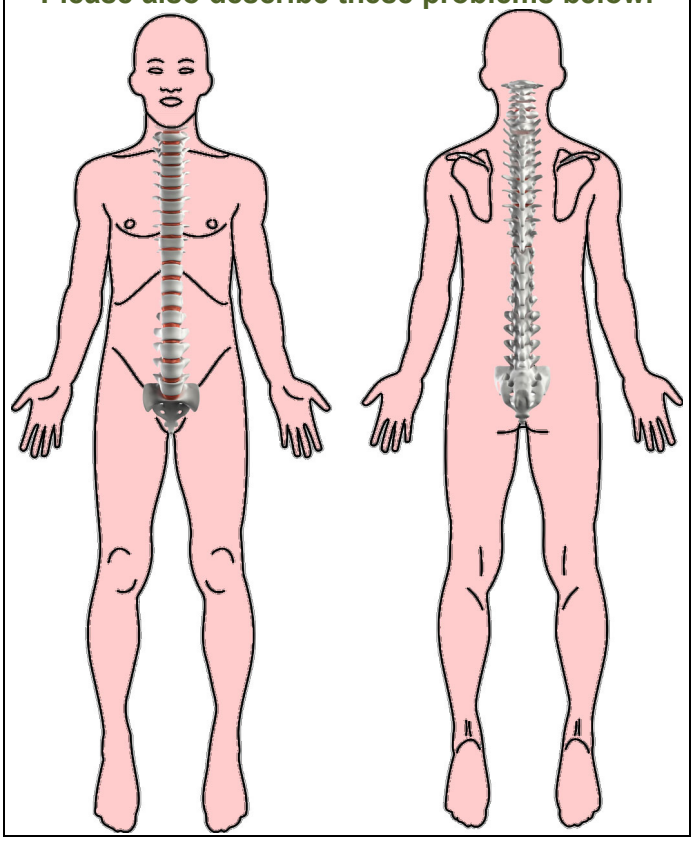
FEMALES ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes** ❑ **No** ❑

Please Fill in Below

If you currently or recently have suffered from the following, ***please check if YES*** ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg / Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Joint Pain / Swelling	❑	❑
Numbness	❑	❑
Frequent Colds	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Anxiety / Depression	❑	❑
Sleep Disorders	❑	❑
Heart Problems	❑	❑
High Blood Pressure	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Asthma	❑	❑
Allergies	❑	❑
Female Issues	❑	❑
Cancer	❑	❑
Hypoglycemia	❑	❑
Diabetes	❑	❑
Osteoporosis	❑	❑
Digestive Problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other: Write in:	❑	❑

Circle the areas where you have any problems. Please also describe these problems below.



Please describe below any health information about your health or symptoms.

Your Signature Below Please

Date: _____