Jonathan Vahue D.C.
Healthy Family Chiropractic
3234 S. Westnedge Ave., Kalamazoo, MI 49008
(269) 567-4111

Outline of Procedure for New Patients

1. All new patients are requested to fill out a personal health/history questionnaire.

2. Your first consultation with a doctor to discuss your health problems.

3. Diagnostic chiropractic, orthopedic, neurological examination procedures and x-rays if necessary to determine if chiropractic care is appropriate for your condition.

4. If your case requires immediate attention, emergency care will be administered.

5. You will be advised as to a time you can return for your “Report of Findings” when your doctor will inform you of your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

6. After your return and receive your “Report of Findings” your recommended program of care will be explained to you.

7. Care will begin and continue as scheduled until your condition has been fully corrected or until the maximum possible improvement has been obtained.

Date: _____

PERSONAL HISTORY

Name: _____Age: ___ D.O.B:___/____/_____ Sex: M F

Address: _____City: _____ State: _____ Zip: _____

Phone (Home)(_____)_____ Marital Status: ❑S ❑M ❑D ❑W
(Cell) (_____)_____
(Work) (_____)_____Ext._____ Number of Children: _____
Occupation: _____ Employer: _____
Social Security Number: _____ Email Address: _____
Emergency Contact: _____ Phone Number: (_____) _____
How were you referred to this office? _____
Who will be Responsible for your bill? ❑Self ❑Spouse/Spouse's Insurance
Type of insurance: ❑None ❑Worker's Comp ❑Auto Insurance ❑Medicare ❑Medicaid ❑Personal Injury ❑Personal/
Group Health Insurance (Name): _____
_____

CURRENT HEALTH CONDITION

Reason for Beginning Chiropractic Care: _____
_____

Other Doctors Seen for this Condition: _____
Is this Condition ❑Job Related ❑Auto Related
If Disabled from Work Please give Dates: _____
Your Approx.: Height _____ Weight _____
Current Prescriptions: _____
_____
Vitamins, Home Remedies, or Other Treatments: _____
_____
Habits: ❑Smoking ❑Drinking ❑Drugs ❑Coffee ❑Soft Drinks
Exercise: ❑None ❑Moderate ❑Daily Type: _____
Family History of: ❑Back Problems ❑Cancer ❑Diabetes ❑Heart Problems ❑Kidney Problems

PAST HEALTH HISTORY

Surgery (Check or Describe): ❑None ❑Appendectomy ❑Tonsillectomy ❑Gall Bladder ❑Hernia ❑Broken Bones
(Fractures or Dislocations) Describe: _____
_____
Other Surgery: _____
Ever on Crutches: ❑Yes ❑No Ever Knocked Unconscious: ❑Yes ❑No
Major Accidents or Falls (Describe with Dates):_____
_____

Hospitalization (Other than Above):_____
_____

Previous Chiropractic Care: ❑Yes ❑No
Doctor's Name and Approximate Date of Last Visit: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

Check Any Of The Following Diseases You Have Had:

❑Appendicitis ❑Malaria ❑Chicken Pox ❑Alcoholism
❑Tuberculosis ❑Diabetes ❑Venereal Infection ❑Diphtheria
❑Whooping Cough ❑Cancer ❑Arthritis ❑Typhoid Fever
❑Anemia ❑Heart Disease ❑Epilepsy ❑Pneumonia
❑Measles ❑Goiter ❑Mental Disorder ❑Rheumatic Fever
❑Mumps ❑Influenza ❑HIV Positive ❑Polio
❑Asthma ❑Pleurisy ❑Eczema ❑Stroke

Check Any Of The Following You Have Had In The Past 6 Months:

Musculo-Skeletal Code
❑Headaches
❑Low Back Pain
❑Mid Back Pain
❑Neck Pain
❑Arm Pain/ Leg Pain
❑Joint Pain/ Stiffness/ Swelling
❑Walking Problems
❑Difficulty Chewing/ Clicking Jaw

Nervous System Code
❑Numbness
❑Paralysis
❑Dizziness
❑Forgetfulness
❑Confusion/ Depression
❑Fainting
❑Convulsions/ Tremors/ Twitching
❑Cold/ Tingling Extremities

Gastro-Intestinal Code
❑Poor/ Excessive Appetite
❑Excessive Thirst
❑Nausea
❑Vomiting
❑Diarrhea/ Constipation
❑Hemorrhoids
❑Liver Trouble
❑Gall Bladder Problem
❑Weight Trouble
❑Abdominal Cramps
❑Gas/ Bloating After Meals
❑Heartburn/ Acid Reflux
❑Black/ Blood Stool
❑Bowel Trouble

General Code
❑Allergies
❑Skin Problems
❑Loss of Sleep
❑Frequent Fever/ Cold/ Flu

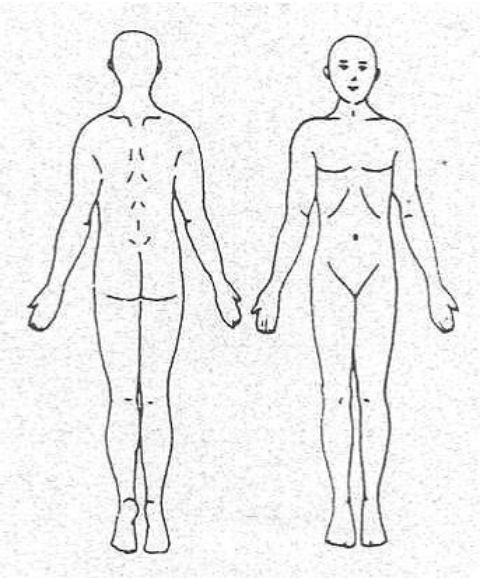
Genito-Urinary Code
❑Bladder/ Kidney Trouble
❑Painful/Excessive Urination
❑Discolored Urine

C-V-R Code
❑Chest Pain
❑Short Breath/ Difficulty Breathing
❑Blood Pressure Problems
❑Heart Problems/ Irregular Heartbeat
❑Chronic Cough
❑Lung Problems/ Congestion
❑Varicose Veins/ Ankle Swelling

E-E-N-T Code
❑Vision/ Eye Problems
❑Sore Throat/ Tonsillitis
❑Earaches/ Ear Problem
❑Hearing Difficulty
❑Sinusitis/ Nose Bleeds
❑Dental Problems

Male/Female Codes
❑Menstrual Irregularity/ Cramps
❑Vaginal Pain/ Infections
❑Breast Pain/ Lumps
❑Prostate/ Sexual Dysfunction
❑Hot Flashes
❑Currently Pregnant

Please Outline On Diagram
The Area Of Your Discomfort



Are there any other symptoms or conditions not listed above that you would like us to be aware of? ❒ Yes ❒ NO
If yes please explain:

Do Not Write Below This Line

Diagnosis:

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of their problem as well as the symptoms corrected and relieved (Corrective Care). Still others want a comprehensive approach to help them reach their highest possible health potential (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your individual program of care.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑Relief Care ❑Corrective Care ❑Comprehensive Care ❑Check here if you want the Doctor to select the type of care Appropriate for your condition.

Patient's Signature: _____

The mission of our office is to offer our patients a drugless, non-surgical approach to health that will allow them to reach their greatest potential…naturally.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me are immediately due and payable.
I hereby authorize the doctor to examine and care for my health as he deems appropriate through the use of Chiropractic, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____Date:_____