Victory Health, LLC Intake Form

Name_____ SS# _____-_____-_____

Address_____City_____St. __ZIP_____

Home #_____Cell # _____ Birthdate_____ age_____

Email_____

Marital Status: (Circle) Single Married Widowed Divorced Spouse Name_____

Employer_____ Work #_____Current Occupation_____

Have you ever been treated by a chiropractor? _____Who referred you to this office? _____

Do you exercise?___ Are you pregnant?____ How did you choose us? Phone Book Friend Sign Family Internet Doctor

Emergency Contact_____Phone #_____ Is it ok to discuss your medical care with them? Yes No

What is your present pain level (1-10) (10 being worst)?_____

What is the worst your pain has been (1-10) (10 being worst)_____

What makes the pain worse?_____

What is the lowest pain level (1-10) (10 being worst)?_____

Did your pain come sudden or gradual?_____

How long have you been hurting?_____

How do you describe the pain?_____

What makes the pain better?_____

What treatments have you done related to your chief complaint? (medication, therapy, etc.)_____

Who is your Primary Medical Doctor? _____

Which pharmacy do you use?_____

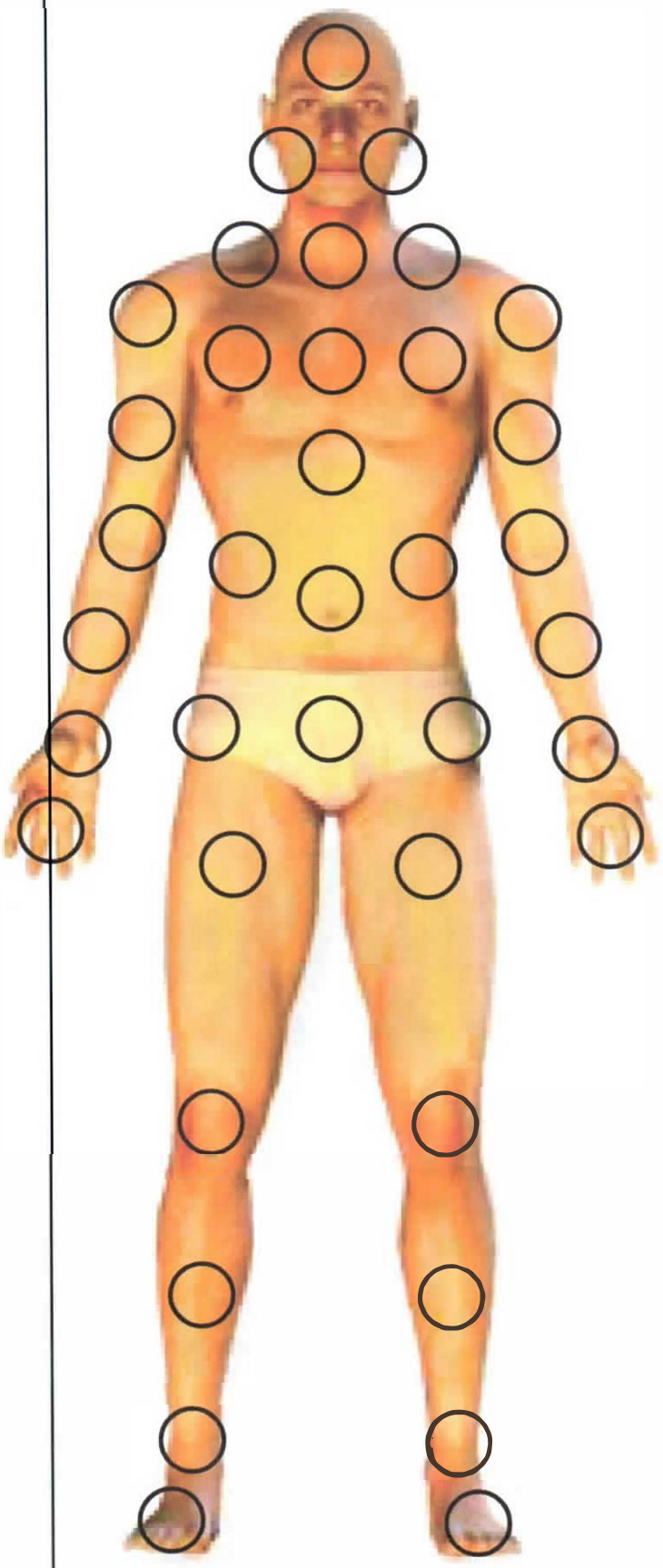
What medications are you taking for your chief complaint?_____

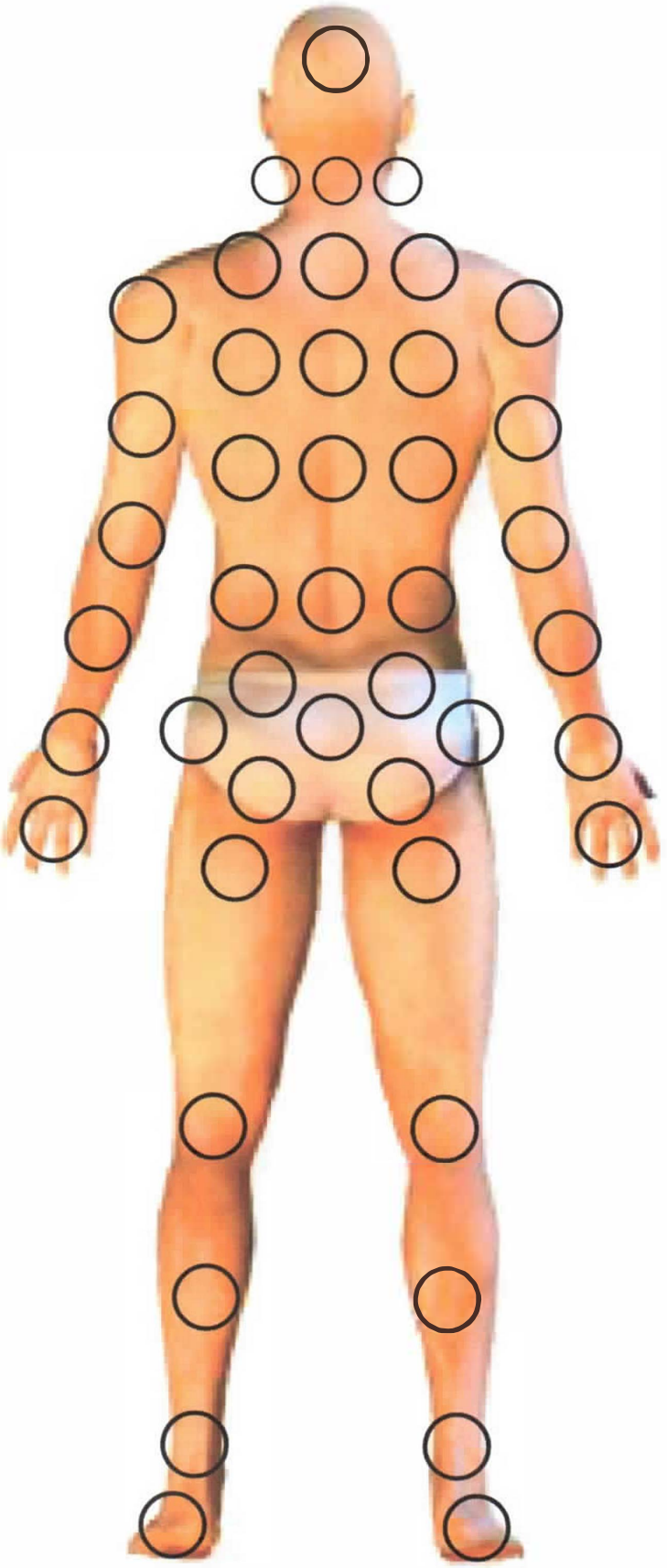
Have you had any tests done related to your chief complaint? (MRI, X-rays, etc.) _____

Do you smoke? _____ Do you consume alcohol?_____ Do you use illicit drugs?_____

Surgeries

Angioplasty	**Arthroscopy**	**Appendectomy**	**Cardiac Catheter**
Gallbladder	**Colonoscopy**	**Coronary Artery Bypass**	**Gastric Bypass**
Hand Surgery	**Heart Valve**	**Hysterectomy**	**Intestinal Surgery**
Laminectomy	**Laparotomy**	**Lung Surgery**	**Mastectomy**
Foot Surgery	**Shoulder**	**Pacemaker**	**Radiation Therapy**
Skin Lesion Excisions	**Spinal Fusion**	**Tonsillectomy**	**Thyroid**
Hip Knee	**Vascular Surgery**	**Other_____**	





Your Health History Checklist

Chronic Conditions (long term)

Allergy	☐ Food ☐ Latex ☐ Anesthetics
Blood & Lymphatic	☐ Anemia ☐ Bleeding Disorders ☐ Immune deficiency ☐ Thrombosis ☐ Need for anticoagulants
Cancer	☐ List type and organ _____
Cardiovascular	☐ Hypertension (high blood pressure) Coronary artery disease ☐ Congestive heart failure ☐ Valvular disease ☐ Atrial fibrillation ☐ Aortic aneurysm ☐ Aortic dissection Heart Attack
Ear/Nose/Throat	☐ Chronic Sinusitis ☐ Hearing Impairment ☐ Tinnitus (ringing in ears ☐ Vertigo (dizziness) ☐ Upper airway allergies (allergic rhinitis) ☐ Chronic laryngeal conditions
Endocrine	☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism
Eye/Vision	☐ Glaucoma ☐ Cataract ☐ Macular degeneration ☐ Color blindness ☐ Ocular misalignment ☐ Retinal abnormality (e.g. detachment, degeneration) ☐ Amblyopia (lazy eye)
Female Reproductive & Breast	☐ Cancer ☐ Endometriosis ☐ Ovarian cysts
Gastrointestinal	☐ Peptic ulcer ☐ Reflux esophagitis ☐ Colitis
HIV/AIDS Opportunistic infections	☐ HIV year diagnosed _____
Kidney & Urologic (urinary tract) **Disease**	☐ Kidney Failure ☐ Chronic infections ☐ Kidney stones ☐ Glomerulonepritis ☐ Nephrotic syndrome ☐ Enlarged Prostate ☐ Chronic prostatitis ☐ Ischemic bowel disease
Liver	☐ Cirrhosis ☐ Hepatitis Type A B C

Your Health History Checklist

Chronic Conditions (long term)

Musculoskeletal / Joint	☐ Degenerative arthritis ☐ Rheumatoid arthritis ☐ Lupus ☐ Lyme arthritis ☐ Gout ☐ Osteoporosis
Neurologic	☐ Stroke ☐ Aneurysm ☐ Parkinson's disease ☐ Multiple sclerosis ☐ Headaches ☐ Seizure disorder (epilepsy) ☐ Alzheimer's / dementia ☐ Peripheral neuropathy ☐ Spina bifida
Psychiatric	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Pre-menstrual syndrome (PMS)
Respiratory	☐ Asthma ☐ COPD ☐ Pulmonary embolus (blood clot to lung) ☐ Collapsed lung ☐ Tuberculosis
Skin	☐ Dermatitis / Eczema ☐ Psoriasis ☐ Skin cancer(s)
Sleep Disorders	☐ Sleep apnea ☐ Narcolepsy ☐ Cataplexy
Other Chronic Conditions	☐ Chronic Pain ☐ Other_____ Fibromyalgia

Family Health History
(please list pertinent illnesses/diseases)

Mother_____

Father_____

Sister_____

Brother_____

Patient Name _____

Patient Date of Birth _____

What Medications Are You Currently Taking?

Medications	Dosage	Frequency (i.e. 2 times a day)

☐ **NONE**

_____

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_____

Do you have any Medication Allergies?

Medications	Reaction	Onset date

☐ **NONE**

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