Today's Date: _____

Dr. Andrea Towers Bondy

857 Health Park Blvd.
Grand Blanc, MI 48439
810-344-9279
vitalitychirogb@gmail.com

Welcome to our office!

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Gender: ☐ Male ☐ Female Female: Are you pregnant? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Last 4 digits of Social Security Number: _____

Occupation: _____

Employer: _____

Primary Care Physician: _____ Phone Number: _____

Contact Information

Phone Number: _____ Email Address: _____

Emergency Contact: _____ Phone Number: _____

Insurance Information

Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____

Policy Holder's DOB: _____ Policy Holders SSN: _____ - _____ - _____

Who is responsible for the finances on this account? _____

- Relationship to patient: _____

Signature of responsible party _____

Complaints and Symptoms

Location of symptom(s): _____

The symptom(s) that prompted me to seek care: _____

_____

Are your symptoms a result of one of the following? ☐ Work injury ☐ Auto accident

When did your symptoms begin? _____

Intensity of pain **NOW**: 0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain)

On average: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms? ☐ Constantly ☐ Intermittent ☐ Frequently ☐ Occasionally

What does it feel like?

Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning

Shooting Throbbing Stabbing Other: _____

What area, if any, does the pain radiate, shoot or travel?

_____

Aggravating and relieving factors: please explain what makes the pain better or worse, movement, certain activities, etc.

What makes the pain **worse**?

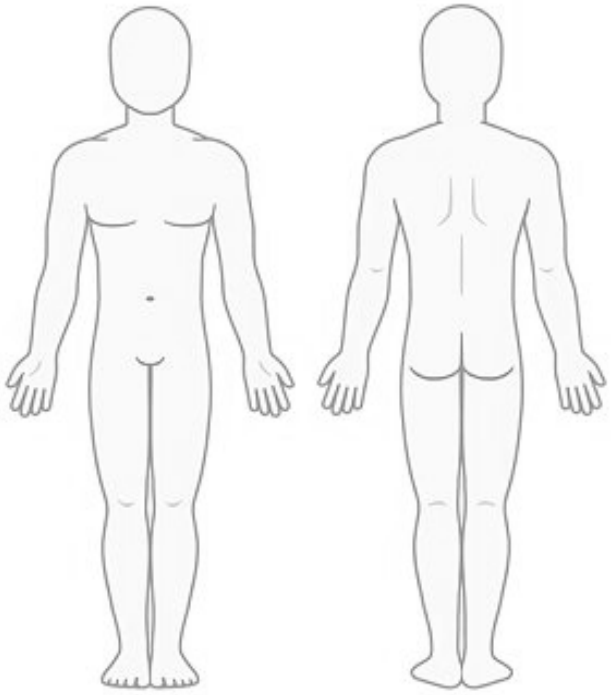
_____

What makes the pain **better?**

_____

Where does it hurt?

Circle the areas on the illustration.



Health History

Review the list of possible medical conditions. If you currently have, or have had any of the following, please mark the box.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Multiple Sclerosis (MS)
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stoke
- ☐ Thyroid Problems

Please list all prescription, over the counter medications, herbs and supplements you are taking:

_____

_____

Please list all surgical procedures you have had: _____

_____

Habits

Alcohol use: Daily Weekly Occasionally How much? _____

Caffeine consumption: Heavy Moderate Light None

Tobacco use: Daily Weekly Occasionally How much? _____

Exercise: Daily Weekly Occasionally How much? _____

Family History

In this section, please check the appropriate box for any health condition on either your mother or father's side.

	Mother	Father
☐ Respiratory Disease	☐	☐
☐ Hypertension	☐	☐
☐ Gastrointestinal Disease	☐	☐
☐ Diabetes	☐	☐
☐ Skin Disease	☐	☐
☐ Neurological Disease	☐	☐

	Mother	Father
☐ Heart Disease	☐	☐
☐ Osteoporosis	☐	☐
☐ Thyroid Disease	☐	☐
☐ Stroke	☐	☐
☐ Cancer	☐	☐
☐ Arthritis	☐	☐

Acknowledgements

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and initial in the area provided. If you have any questions, the office staff will be more than happy to help you.

_____ I give Dr. Andrea Towers Bondy my permission to use her professional judgment to provide me with care that can best help me in restoring my health. I understand that care offered at Vitality Chiropractic is designed to reduce or correct vertebral subluxation. Chiropractic care is a separate and distinct healing art form from medicine and does not proclaim to cure any disease.

_____ **PARENTS ONLY**: I, _____, give Dr. Andrea Towers Bondy my permission to evaluate and treat _____ with chiropractic care.

_____ I may request a copy of the Privacy Policy at any time. I understand that the policy describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I understand that an x-ray examination is a requirement for treatment. Diagnostic radiographs provide Dr. Andrea Towers Bondy with the information she needs to determine my diagnosis and treatment at Vitality Chiropractic.

_____ **WOMEN ONLY**: I realize that an x-ray examination may be hazardous to an unborn child and I certify that, to the best of my knowledge, I am not pregnant.
Date of last menstrual period: _____

_____ I grant permission to be called or texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern(s).

_____ _____

Signature Date