Van Family Chiropractic

12800 Preston Rd., Suite 200
Dallas, TX 75230
(214) 750-9992
www.evvdc.com

Name ______________________________ Age ______ Date of Birth ____-____-_____

Social Security Number:_______-_____-_______

Address ____
Street or PO Box City State Zip

Phone(Home) _________________ (Work) ______________(Cell) _________________

E-Mail Address _________________________________ Employer: ________________

Sex: M F Marital Status: Single Married Widowed Div.
Spouse's Name ____________________ Spouse's Occupation:__________________
How many children? _____
Names & Ages of Children____
____

How did you find out about Van Family Chiropractic and/or Dr. Erin?
____

Occupation, please describe what type of work you do daily: ______________________
____

Have you ever consulted a Doctor of Chiropractic? ___________
If yes, who? ________________________
When? ____________________________ How long were you under care?_________
Did you receive X-rays?____________ MRI?___________ When? ________________

Please describe what brought you into the office today_____________________________
____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered:

X_________________________________ _________
Signature *Date*

Privacy Act:
I consent to the use of my protected health information by Dr. Van Veldhuizen for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations. HIPAA Compliance.

X_________________________________ _____________________ _________
Signature of Patient *Printed Name of Patient* *Date*

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Do you now, or have you ever suffered from:

Dizziness ___	Heart trouble ___	Diabetes ___	Lung problems___
Asthma ___	High Blood Pressure ___	Neuritis ___	Digestive disorder ___
Heart Burn ___	Headaches___	Arthritis ___	Sinus trouble ___
Cancer___	Nervousness ___	Anemia ___	Trouble Sleeping ___
Low Energy___	Poor Circulation ___	Anxiety ___	Menstrual Pain or Difficulties ___
Allergies ___	Tire Easily ___	TB___	Tingling in Hands/Feet ___
Irritability___	Depression___	Tumor ___	Numbness in Hands/Feet ___

Please list any other health concerns you have at this time: ______________________________

____

What would you like to re-gain in your life by becoming healthier? ________________________

____

What are your goals for your experience here at Van Family Chiropractic?____________________

____

Do you eat fresh fruits and/or vegetables on a daily basis? If not, how often?___________

____

Physical Stressors:

Any Accidents or Injuries:____

____

Childhood Injuries:____

Broken Bones:____

Surgeries:____

____

____

Any Other Medical Procedures:____

____

____

Do you do any physical activity on a daily basis? _________________________________

If yes, what type? ____

Chemical Stressors:

List any and all Prescriptions:____

____

List any and all OTC drugs: ____

____

Do you smoke or chew tobacco?____

Do you drink alcohol, how often?____

Do you drink diet sodas or eat sugar-free foods? ___________________________________

Emotional Stressors:

Have you had any strong emotional stressors either recently, or that has an effect on your daily life?____

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Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, __________________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

____ ____________
(signature) (date)

Consent to evaluate and adjust a minor child
I, ________________________________ being the parent or legal guardian of ______________________
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

For all Female Patients of Child-Bearing capability: **Pregnancy Release**
This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Van Veldhuizen has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: _______________________

____ ____________

(signature) (date)

What aspects of Wellness do you want for yourself? (please check as many as you'd like)

___ More Energy	**___ Better Sleep**	**___ Freedom from pain**
___ Better Concentration	**___ Enhanced emotional Well-being**	**___ Reduce/Eliminate Medication use**
___ Improved Digestion	**___ Improved strength And endurance**	**___ Greater resistance to Disease**
___ Easier breathing, Deeper breaths	**___ Better sports performance**	**___ Better reaction time/reflexes**
___ Better Balance	**___ Improved Posture**	**___ Overall Health Improvement**
___ Increased zest for Living		

Wellness goals for your family: ____

____

____

____