VALEO
HEALTH AND WELLNESS CENTER

Office Use Only

Practitioner: _____

◯ Thank you note

◯ CC

◯ Eclipse

Name	DOB	Age	Date

Address	City	State	Zip	Email/Newsletter

Ph: H ( ) W ( ) M ( )	Height	Weight	Gender
Cell Phone Carrier			

Preferred Contact O Ph: (Home) O Ph: (Work) O Ph: (Mobile) O Email O Text

Do you have Medicare coverage? O Yes O No

Emergency Contact Information

Name	Relationship to patient	Ph ( )

How were you referred to our office?	O Single	O Married
	O Divorced	O Widowed

Additional Information

Language
- O English
- O Spanish
- O Other

Ethnicity
- O Hispanic or Latino
- O Not Hispanic or Latino
- O Decline to answer

Race
- O White
- O Hispanic or Latino
- O Asian
- O Black or African American
- O Decline to answer
- O Other

HIPAA acknowledgement of receipt of notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at anytime. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at anytime.

Client Name **Signature** **Guardian** **Date**

Goals for my care: People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will evaluate your needs and desires when recommending your program of care. Please check the type of care desired, so that we may be guided by your wishes.

O **Relief Care:** Symptomatic relief of pain or discomfort.
O **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
O **Comprehensive Care:** Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible.

Please list health concerns according to their severity. Rate from… 1 (Mild) to 10 (Unbearable)

Health Concern	Severity	Episode start date?	Had this before? When?	Constant or intermittent?

Since the problem started, is it: O Same O Improving O Worse
Does it travel/radiate anywhere? O No O Yes O Where _____
What makes it better? _____ **What makes it worse?** _____
Do you have a family history of this or similar symptoms? O No O Yes / Explain _____
If you are experiencing pain, is it: O Sharp O A Dull Ache O Stabbing

Have other doctors seen you for this condition? O No O Yes / Diagnosis _____
O Medical O Chiropractor O Other **What was done?** _____
Are you allergic or sensitive to fragrances or oils? O Yes O No

List all past accidents (auto or work), injuries, surgeries, X-rays, trauma - physical or emotional, procedures.

Type	Date	Doctor / Hospitalization / X-Rays

List all prescription drugs, over-the-counter-drugs, and all supplements you are currently taking.

Name of drug or supplement	Taken for how long?	For what purpose?	How much?

List any known allergies

Physical scars?

Do you have any scars? ○ **No** ○ **Yes** **Where** _____

The Beginning Years

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illness? If yes, what?			
Did you have any serious falls as a child?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Were you vaccinated?			
Adult: 18 to present	**Yes**	**No**	**Unsure**
Are you pregnant? If yes, when due?			
Do you have a pacemaker?			
Do you have any metal in your body? If yes, where?			

Please circle all that apply.

1. How have you taken care of your health in the past?

A - Medications **B** - Emergency room **C** - Routine medical **D** - Exercise **E** - Nutrition/Diet **F** - Holistic care **G** - Vitamins **H** - Chiropractic **I** - Other (Please specify.) _____

2. How did the previous method(s) work out for you?

A - Bad results **B** - Some results **C** - Great results **D** - Nothing changed **E** - Did not get worse **F** - Did not work very long **G** - Still trying **H** - Confused

3. Are you concerned that this condition is negatively affecting or will negatively affect any of the following?

A - Job **B** - Kids **C** - Future ability **D** - Marriage **E** - Self-esteem **F** - Sleep **G** - Time **H** - Finance **I** - Freedom

4. Are you concerned that your health condition(s) might turn into any of the following?

A - Family health problems **B** - Heart Disease **C** - Cancer **D** - Diabetes **E** - Arthritis **F** - Fibromyalgia **G** - Depression **H** - Chronic fatigue **I** - Need surgery

5. Has your health condition affected your job, relationships, finances, family or other activities? ○ **No** ○ **Yes (If yes, please explain.)**

6. If you have health issues, what have they cost you? (time, money, hope, happiness, freedom, sleep, etc)? Please describe.

7. What do you think the time frame will be to regain your health?