



VAN FAMILY CHIROPRACTIC

DR. ERIN VAN VELDHUIZEN

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

Social Security Number: _____ - _____ - _____

Address

Street or PO Box Apt# 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? _____