

Dr. Neil Vance  
Chiropractic Physician

Vance Chiropractic Center  
251-A Wilmot Dr. Gastonia, NC  
(704) 867 - 6789

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Street Address and Number: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

**Sex:** Male Female # of Children: \_\_\_\_\_ **Circle One:** Married Single Widowed Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_

In case of emergency, please contact (include phone): \_\_\_\_\_

E-mail address \_\_\_\_\_

Please describe your condition(s) beginning with the most severe.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

When did this/these conditions begin? \_\_\_\_\_ Is the condition getting (circle) better worse same

What is the cause of your condition(s). \_\_\_\_\_

What makes the condition feel better or worse? \_\_\_\_\_

Do you Eat 10 Serving of Fruits and Vegetables Everyday. Yes \_\_\_\_\_ No \_\_\_\_\_

Do You Drive a lot. Yes \_\_\_\_\_ No \_\_\_\_\_

Have you seen any other physician for this condition? (Please list name and dates.) \_\_\_\_\_

Have you ever been treated by another chiropractor? (If yes, who/when/same condition?) \_\_\_\_\_

Have you ever had similar symptoms to present condition? \_\_\_\_\_

Are you currently treating with any other physician (if yes, please explain) \_\_\_\_\_

Please list your family physician, location (city and state), & Medications you are currently taking:

Please list your complete surgical history (give dates and type of surgery):

Have you ever been involved in an automobile accident? (If yes, please give dates & explain accident):

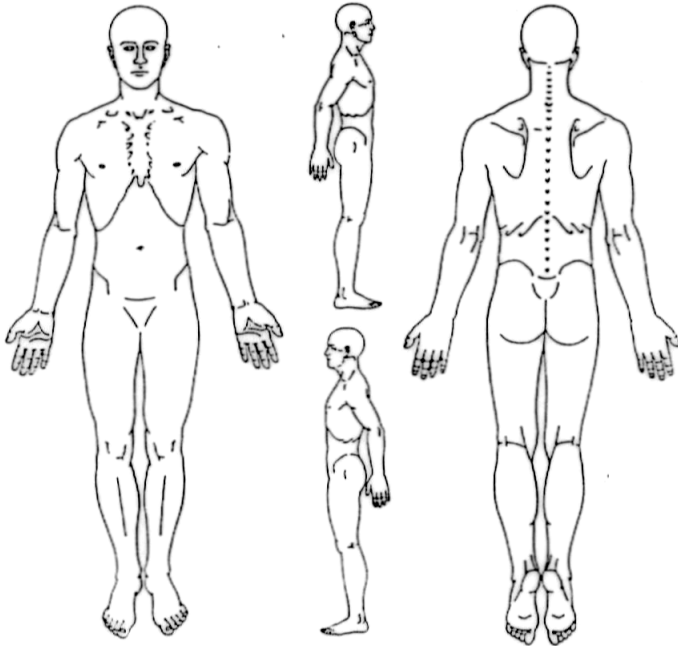
Name of person responsible for payment (if different from applicant) \_\_\_\_\_

Would you like us to file insurance for you?(Please Circle) YES NO Have you met your deductible? YES NO  
Name of insurance company (if applicable) \_\_\_\_\_

PLEASE CHECK THE SPACES BELOW FOR SYMPTOMS YOU ARE CURRENTLY HAVING.

If you are experiencing any of the following conditions, please indicate on the diagrams below.

A=ACHE      B=BURNING      N=NUMBNESS  
P=PAIN      S=STABBING      O=OTHER



**1. HEADACHES**

- \_\_\_ 2. DIZZINESS
- \_\_\_ 3. NECK PAIN
- \_\_\_ 4. NECK STIFFNESS
- \_\_\_ 5. UPPER BACK PAIN
- \_\_\_ 6. SHOULDER PAIN
- \_\_\_ 7. ARM OR HAND PAIN
- \_\_\_ 8. NUMBNESS OR TINGLING
- \_\_\_ 9. MID BACK PAIN
- \_\_\_ 10. LOW BACK PAIN
- \_\_\_ 11. HIP OR BUTTOCK PAIN
- \_\_\_ 12. LEG OR FOOT PAIN
- \_\_\_ 13. EAR NOISES
- \_\_\_ 14. SINUS INFECTION
- \_\_\_ 15. VISION PROBLEMS
- \_\_\_ 16. ALLERGIES
- \_\_\_ 17. CHEST PAIN
- \_\_\_ 18. DIFFICULT BREATHING
- \_\_\_ 19. FREQUENT URINATION
- \_\_\_ 20. PROSTATE PROBLEMS
- \_\_\_ 21. ARTHRITIS
- \_\_\_ 22. BURSITIS
- \_\_\_ 23. STROKE

I hereby authorize Vance Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. VANCE'S OFFICE FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

X \_\_\_\_\_  
Signature of patient, or of Guardian authorizing care

\_\_\_\_\_  
Date