



# The Vitality Cove

## New Patient Information & Comprehensive Health History Form

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Date: \_\_\_\_\_

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### Page 1: Patient Information & Current Health Concerns

#### Patient Details

- Patient Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  Other:  
\_\_\_\_\_
- Address: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_
- Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_
- Referred By: \_\_\_\_\_
- 

#### Health Overview

- Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_
- Overall Health (Circle one): EXCELLENT | GOOD | FAIR | POOR

#### Primary Reason for Visit

- Chief Complaint / Primary Reason:  
\_\_\_\_\_  
\_\_\_\_\_
- Duration of Issue: \_\_\_\_\_
- What Makes It Better/Worse? \_\_\_\_\_
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#### Previous & Current Care

— Previous Treatments for This Complaint:

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— Other Current Complaints / Concerns:

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— Current Medications / Supplements / Herbs:

*(include dosage/frequency/reason if known)*

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— List Any Restrictions (diet, activity, allergies):

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### Lifestyle Habits

— Smoke cigarettes?  Yes  No If yes, how much/day? \_\_\_\_\_

— Drink coffee?  Yes  No If yes, how much/day? \_\_\_\_\_

— Drink alcohol?  Yes  No If yes, how much/often? \_\_\_\_\_

*Continued on Page 2...*

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## Page 2: Health History & Acknowledgment

### Physician & Health History

— Currently under the care of a physician?  Yes  No

*If yes, name, phone, and date of last visit:*

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— Major Illnesses (with approximate dates):

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— Surgeries / Operations (with approximate dates):

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— Past Accidents or Injuries (with details & dates):

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## Family & Household Information

- Marital Status (Circle one): S (Single) | M (Married) | D (Divorced) | W (Widowed)
- Spouse/Partner Name: \_\_\_\_\_
- Spouse/Partner Health (Circle one): EXCELLENT | GOOD | FAIR | POOR
- Number of Children: \_\_\_\_\_
- Health of Children:  
\_\_\_\_\_  
\_\_\_\_\_

## Family Health History

- Check all that apply and provide details/relationship:  
 Cancer  Diabetes  Heart  Thyroid  Autoimmune  Other: \_\_\_\_\_

Details:

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## Emergency Contact

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

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## Page 1: Patient Information & Current Health Concerns

### Patient Details

- Patient Name: <form field>
- Date of Birth: <form field> Age: <form field> Gender:  Male  Female  Other: <form field>
- Address: <form field>
- City: <form field> State: <form field> ZIP: <form field>
- Email Address: <form field>
- Home Phone: <form field> Cell/Work Phone: <form field>
- Occupation: <form field> Employer: <form field>
- Referred By: <form field>

### Health Overview

- Height: <form field> Current Weight: <form field>
- Overall Health (Circle one): EXCELLENT | GOOD | FAIR | POOR

### Primary Reason for Visit

- Chief Complaint / Primary Reason:  
<multiline form field>
- Duration of Issue: <form field>
- What Makes It Better/Worse? <form field>

## Previous & Current Care

- **Previous Treatments for This Complaint:**  
<multiline form field>
  
- **Other Current Complaints / Concerns:**  
<multiline form field>
  
- **Current Medications / Supplements / Herbs:**  
(include dosage/frequency/reason if known)  
<multiline form field>
  
- **List Any Restrictions (diet, activity, allergies):**  
<multiline form field>

## Lifestyle Habits

- Smoke cigarettes?  Yes  No If yes, how much/day? <form field>
- Drink coffee?  Yes  No If yes, how much/day? <form field>
- Drink alcohol?  Yes  No If yes, how much/often? <form field>

Continued on Page 2...

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## Page 2: Health History & Acknowledgment

### Physician & Health History

- **Currently under the care of a physician?**  Yes  No  
If yes, name, phone, and date of last visit:  
<multiline form field>
  
- **Major Illnesses (with approximate dates):**  
<multiline form field>
  
- **Surgeries / Operations (with approximate dates):**  
<multiline form field>
  
- **Past Accidents or Injuries (with details & dates):**  
<multiline form field>

### Family & Household Information

- **Marital Status (Circle one):** S (Single) | M (Married) | D (Divorced) | W (Widowed)
- **Spouse/Partner Name:** <form field>

- **Spouse/Partner Health (Circle one):** EXCELLENT | GOOD | FAIR | POOR
- **Number of Children:** <form field>
- **Health of Children:**  
<multiline form field>

### Family Health History

- **Check all that apply and provide details/relationship:**  
 Cancer  Diabetes  Heart  Thyroid  Autoimmune  Other: <form field>

Details:  
<multiline form field>

### Emergency Contact

- **Name:** <form field> **Relationship:** <form field> **Phone:** <form field>

### HIPAA Acknowledgment & Privacy Notice Receipt

I acknowledge receipt (or offer) of the **Notice of Privacy Practices (NPP)** for The Vitality Cove. I understand my rights regarding my protected health information (PHI) and consent to its use for treatment, payment, and healthcare operations as allowed by law.

**Patient Signature (or Guardian if Minor):** <form field> **Date:** <form field>

**Printed Name (if different):** <form field> **Relationship (if Guardian):** <form field>

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I understand my rights regarding my protected health information (PHI) and consent to its use for treatment, payment, and healthcare operations as allowed by law.

**Patient Signature (or Guardian if Minor):** <form field> **Date:** <form field>

**Printed Name (if different):** <form field> **Relationship (if Guardian):** <form field>

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*This form assists in developing a complementary wellness plan (chiropractic care, acupuncture, nutrition, herbal therapies, massage, energy healing, etc.) and is **not** intended to diagnose, treat, or cure any disease. Your information is protected under HIPAA.*

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