ELAN VITAL MEDICAL CTR
21 WEST STREET
WORCESTER, MA 01609
TEL. 508-753-0006
FAX. 508-770-0618

PATIENT INFORMATION

(Please print clearly)

WELCOME

The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to our care, we will not accept you as a patient but will refer you to another health care provider.

Last Name_____

First_____MI_____

Street_____

City_____State_____Zip_____

Phone ( ) _____-_____Email Address_____

Birth Date_____-_____-_____Sex:_____Male_____Female

Employer_____Work Phone ( )_____-_____

Who can we thank for referring you to our office?_____

I understand and agree that the doctor has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. I further understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that, unless other arrangements are made with your office, all services are rendered to me are charged directly to me and that I am personally responsible for payment.

Signature_____Date_____-_____-_____

PLEASE VISIT US ONLINE AT: **WWW.DRKARENWAY.COM**

Name_____

What is the reason for your visit?_____

_____

_____

What do you think caused your problem?_____

When did this condition begin?_____Has this condition occurred before? ( ) Y ( ) N
What type(s) of therapy have you tried for this condition?

( )conventional drugs	( )chiropractic	( )acupuncture
( )diet modification	( )vitamin/minerals	( )herbs
( )homeopathy	( )other_____	

Laboratory tests performed (e.g. blood, urine, stool, hair analysis)_____

_____

Outcome of tests_____
What diagnosis were you given?_____

Is your health currently: ( )getting better ( )getting worse ( )staying same
How do you know?_____

Please list any other health concerns/conditions, even if you think they may not be important._____

_____

_____

Primary care physician_____Date of last physical exam_____

Please list all medications you have taken over the past 3 months (prescription or over the counter)

Drug Name	Start Date	Stop Date	Reason For It	Results

Please list all of your medication allergies

1. 2. 3.

4. 5. 6.

Please list all hospitalizations or surgeries

1._____ Year_____

2._____ Year_____

3._____ Year_____

Have you EVER been on frequent or prolonged antibiotic therapy? ( )Y ( ) N
Any medications devices/prosthetics/implants ( )Y ( )N describe:_____

WOMEN

Age of onset of menstruation_____ Are you pregnant? ( ) Y ( ) N
Age of onset of menopause_____ Hysterectomy ( )Y ( )N
Number of children_____ Number of miscarriages_____
Length of menstrual cycle_____days Interval of time between cylces_____days
Duration of flow_____days Is your flow ( )Light ( )Medium ( ) Heavy
Date last period began_____ Date of last PAP_____
Do you have:
( )irregular periods ( )cramps/pain with period
( )tension/depression before period ( )hot flashes at any time
( )pain during intercourse ( )any unusual bleeding or discharge

Do you smoke cigarettes? ( )Y ( )N _____packs/day How many years____
Do you smoke cigars? ( )Y ( )N _____cigars/day How many years____
Do you do illegal drugs? ( )Y ( )N amount/type_____
Do you drink alcohol? ( )Y ( )N _____drinks/week
Do you drink caffeine ( )Y ( )N _____cups/per day
How many cups of water do you drink each day?_____
Do you exercise regularly? ( )Y ( )N If yes, what kind and how often?_____
_____

Are you on a special diet? ( )Y ( )N If yes, what kind?_____
_____

Please list everything you eat and drink for 3 days.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Please list all supplements/herbs/homeopathic you are currently taking.

Name/Type	Dosage	Reason For It

Please list your special interests and passions:_____

_____

_____

Please check the boxes next to all illnesses you have or have had.

( ) Atrial Fibrillation	( ) Colon Polyps	( ) Cancer: Colon
( ) Angina Pectoris	( ) Irritable Bowel	( ) Cancer: Esophagus
( ) Artifical Heart Valve	( ) Ulcers	( ) Cancer: Stomach
( ) High Blood Pressure	( ) Crohn's Disease	( ) Cancer: Pancreas
( ) Pacemaker	( ) Ulcerative Colitis	( ) Cancer: Prostate
( ) High Cholesterol	( ) Liver Cirrhosis	( ) Cancer: Breast
( ) Heart Attack	( ) Hepatitis	( ) Excessive Alcohol Use
( ) Bleeding Disorder	( ) Gallstones	( ) Drug Abuse
( ) Emphysema	( ) Lactose Intolerance	( ) Depression
( ) Asthma	( ) Pancreatitis	( ) Anxiety
( ) Tuberculosis	( ) Diverticulosis	( ) Suicide Attempt
( ) HIV/AIDS	( ) Sprue	( ) Stroke
( ) Diabetes	( ) Esophagitis	( ) Migraine Headache
( ) Osteoporosis	( ) Anemia	( ) Endometriosis
( ) Thyroid Disorder	( ) Latex Allergy	( ) Arthritis

Have you had the following immunizations:

( ) Polio	( ) tetanus booster (last 10 yr)
( ) DPT (diphtheria/pertussis/tetanus)	( ) Hepatitis B
( ) Measles	( ) HPV (human papillo virus)
( ) Mumps	( ) Others_____
( ) Small Pox	

Please list any family members who have had any of the following problems.

Disease	Relation To You	Disease	Relation To You
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other		Alcohol Abuse	
Obesity		Hepatitis	
Diabetes		Osteoporosis	
Hypertension		Liver Disease	
Heart Disease		Other:	
High Cholesterol		Other:	

Please circle your answer:

Date of last colonoscopy (if over age 50)	Year:	Never – Don't know
Date of last mammogram (if female)	Year:	Never – Don't know
Date of last bone density test (for osteoporosis)	Year:	Never – Don't know

METABOLIC BIOTRANSFORMATION QUESTIONNAIRE

Patient Name:_____Date:_____
Rate each of the following symptoms based upon y our typical health profile
Point Scale
0-Never or almost never have the symptoms
1-Occasionally have it, effect is not severe
2-Occasionally have it, effect is severe
3-Frequently have it, effect is not severe
4-Frequently have it, effect is severe

HEAD
____Headaches
____Faintness
____Dizziness
____Insomnia
____Total

EYES
____Watery or itchy eyes
____Swollen, reddened or sticky eyelids
____Bags or dark circles under eyes
____Blurred or tunnel vision
____Total

EARS
____Itchy ears
____Earaches, ear infections
____Drainage from ear
____Ringing in ears, hearing loss
____Total

NOSE
____Stuffy nose
____Sinus problems
____Hay fever
____Sneezing attacks
____Excessive mucus formation
____Total

MOUTH/THROAT
____Chronic coughing
____Gagging, frequent need to clear throat
____Sore throat, hoarseness, loss of voice
____Swollen or discolored tongue, gums, lips
____Canker sores
____Total

SKIN
____Acne
____Hives, rashes, dry skin
____Hair loss
____Excessive sweating
____Flushing, hot flashes
____Total

HEART
____Irregular or skipped heartbeat
____Rapid of pounding heartbeat
____Chest pain
____Total

LUNGS
____Chest congestion
____Asthma, bronchitis
____Shortness of breath
____Difficulty breathing ____Total

DIGESTIVE
____Diarrhea
____Constipation
____Bloated Feeling
____Belching, passing gas
____Heartburn
____Intestinal/stomach pain
____Total

JOINTS/MUSCLES
____Pain or aches in joints
____Arthritis
____Stiffness or limitation of movement
____Pain or aches in muscles
____Feeling of weakness or tiredness
____Total

WEIGHT
____Binge eating/drinking
____Craving certain foods
____Excessive weight
____Compulsive eating
____Water retention
____Underweight
_____Total

ENERGY/ACTIVITY
____Fatigue, sluggishness
____Apathy, lethargy
____Hyperactivity
____Restlessness
_____Total

MIND
____Poor memory
____Confusion, poor comprehension
____Poor concentration
____Poor physical coordination
____Difficulty in making decisions
____Stuttering or stammering
____Slurred speech
____Learning disabilities
____Total

EMOTIONS
____Mood Swings
____Anxiety, fear, nervousness
____Anger, irritability, aggressiveness
____Depression
_____Total

OTHER
____Frequent illness
____Frequent or urgent urination
____Genital itch or discharge
____Total

Body Type Evaluation Form

Instructions: For each subject below, circle the one answer that describes you best.

	VATA	PITTA	KAPHA
AMOUNT OF HAIR	average	thinning	thick
TYPE OF HAIR	dry	medium	oily
COLOR OF HAIR	light brown	reddish/gray	dark brown, black
SKIN	dry, rough	soft, med. oily	oily, moist
COMPLEXION	darker	pink to red	pale, white
EYES	small	medium	large
WHITES OF THE EYES	blue or brown	yellow or red	white and glossy
SIZE OF TEETH	very large or very small	small to medium	medium to large
TEETH	shaded	yellowish	pearl white
MENTAL ACTIVITY	quick mind, restless	sharp intellect, aggressive	calm, steady, stable
MEMORY	short term is best	good general memory	long term is best
EXERCISE TOLERANCE	low	medium	high
DREAMS	fearful, flying, running, jumping	anger, fiery, violent	water, clouds, relationships, romance
WEATHER	aversion to cold	aversion to hot	aversion to damp, cool
SLEEP	interrupted, light	sound, medium length	sound, heavy, long
REACT TO STRESS	excite very quickly	anger easily, quick temper	slow to get irritated
RESTING PULSE RATE (beats/min)			
WOMEN	80-100	70-80	60-70
MEN	70-90	60-70	50-60
BODY SIZE	small frame	medium frame	large frame
WEIGHT	thin, hard to gain	medium weight	heavy, easy to gain
ENDURANCE	poor	good	excellent
STRENGTH	poor	good	excellent
HUNGER	irregular	sharp, needs food	can easily miss meals
FOOD & DRINK	prefer warm	prefer cold	prefer dry & warm
EAT	quickly	med. speed	slowly
FINANCIAL	doesn't save, spends quickly	saves but big spender	saves regularly, accumulates wealth
SEX DRIVE	variable, irregular	moderate	strong
ELIMINATION	dry, hard, constipation	many, soft to normal	heavy, slow, thick regular
WALK	fast, quickly	average	slow & steady
VOICE	high pitch, fast	medium pitch, clear	low pitch, deep resonating
MOODS	changes quickly	slowly changing	steady, non-changing
TOTALS	☐ **VATA**	☐ **PITTA**	☐ **KAPHA**

ELAN VITAL MEDICAL CENTER

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC HEALTHCARE

INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare the necessary reports and forms to assist me in making collections from the insurance company and that I hereby authorize and assign all benefits so that all bills are paid directly to the Doctor's Office to be credited to my account. However I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. I understand and agree that a Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and/or VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body and opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I also agree that I am responsible for all bills incurred at the office and assign all insurance benefits to this office.

I have read and understand the foregoing.

NAME: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____