Vreeland CLiNiC
Science and Nature. Balanced for Health.

Patient Personal Record
(Confidential)

Today's Date:_____

Full Name:_____Nickname:_____

Legal Guardian (if under 18):_____

Complete Address:_____

_____

Email Address:_____

Phone #: Home:_____Business:_____

Cell:_____

Preferred method of contact: (Circle one) Email Home# Cell# Business#

Sex: _____M _____F Age:_____ DOB:_____

Emergency Contact:_____Phone:_____

Marital Status: (*optional, circle one*) Single, Married, Partnered, Divorced, Separated, Widowed

Credit Card Policy– For your convenience the Vreeland Clinic keeps a copy of your credit card on file to expedite the processing of your requests. This allows us to send you test kits, order supplements, schedule paid phone consults, etc. without delay. We will never charge your card without your consent.
CC#_____Exp Date:_____Name on Card:_____

Occupation:_____

Place of Employment:_____

Job Description: (ex: heavy lifting, computer/sitting all day, stressful etc.)_____

_____

_____

Recreational Habits and Hobbies (how often do you work out and what):_____

_____

_____

Referred By:_____

Present Chief Complaint

Reason for visit today:_____

_____

_____

When did your problem begin?_____

Explain how:_____

_____

_____

Have you had this problem previously?_____ If so when?_____

What concerns you most about your condition?_____

_____

_____

Does it bother your work, sleep, other?_____

_____

Is it getting worse? _____Yes _____No

Have you been given a diagnosis for your condition_____

_____

_____

Have you had treatment for this condition? _____Yes _____No

When, if treated?_____ Results?_____

_____

Treated by: (D.C., M.D., other) _____

_____

List all medications that you are presently taking: birth control, over-the-counter meds (tums, aspirin, etc. and how often) *Please use additional paper if more room is needed.*

_____

_____

_____

_____

_____

_____

_____

List all vitamins, herbs, homeopathics etc. that you are presently taking on a regular basis:

_____

_____

_____

_____

_____

List any other doctors you are currently seeing and why:_____

_____

_____

_____

_____

Related Health History

Some health conditions are a result of our environment in the way we live and work.

List any electrical items you may use at home or work. (electric blankets, heating pads, computers, diagnostic machinery, etc.)

_____

_____

_____

_____

_____

List any chemicals you use around the home or at work. (Paint, varnish, photography chemicals, fertilizers, pesticide sprays, asbestos, etc.)

_____

_____

_____

_____

_____

Do you have any mercury fillings? If so, how long have you had them?_____

_____

_____

Family Health History

Some health conditions are a result of hereditary weakness. Information about the immediate family members, *brothers*, *sisters*, *parents*, or *grandparents* will give us a better understanding of your total health picture. *Please use additional paper if more room is needed*.

Relationship	Present & Past Health Problems
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History– List all surgeries, pregnancies, illnesses, childhood diseases, etc.
Please use additional paper if more room is needed.

_____

_____

_____

_____

_____

_____

_____

Social History– Example: smoking, drinking, alcohol abuse, substance abuse, exercising...How much or how long? *Please use additional paper if more room is needed.*

_____

_____

_____

_____

_____

In order to better serve your health goals please indicate the extent of the care you desire from the Vreeland Clinic.

☐ Wellness care to optimize my health and reduce my probability of future illness including, but not limited to my present complaint.

☐ Relief of my present symptoms only. This may mean that the actual cause of the these symptoms may be left untreated.