



Mae Costello, Lac  
6018 SE Stark St, Portland, OR 97215  
Phone: 503-808-9145 | Fax: 503-473-8085  
www.vitalhealthdx.com

Confidential Patient Information

Name \_\_\_\_\_

Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

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

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

May I contact you at work? \_\_\_\_\_ May I email you? \_\_\_\_\_

Emergency Contact name and Phone Number \_\_\_\_\_

Who may I thank for referring you to this clinic? \_\_\_\_\_

Insurance Information

Employer \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

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

Relationship to insured if other than self: \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Policy/Plan # \_\_\_\_\_

Co-pay amount: \_\_\_\_\_ SSN \_\_\_\_\_

Deductible per year: \_\_\_\_\_ Has deductible been met? \_\_\_\_\_

Health Information

Main health concern(s) for which you are seeking relief \_\_\_\_\_

Have you been given a diagnosis for this condition? If so, what? \_\_\_\_\_

What kinds of treatments have you tried, and to what extent have they helped? \_\_\_\_\_

When did this condition start? \_\_\_\_\_

Is this condition work related? \_\_\_\_\_ Car Accident? \_\_\_\_\_ Date of Injury \_\_\_\_\_

Past Health History

Major Illnesses: \_\_\_\_\_



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Major surgeries: \_\_\_\_\_  
Other significant physical /emotional traumas: \_\_\_\_\_  
Allergies (drugs, foods, latex, chemicals): \_\_\_\_\_  
Medications you currently take: \_\_\_\_\_  
Do you smoke? \_\_\_\_ How much? \_\_\_\_\_ Drink alcohol? \_\_\_\_ How often? \_\_\_\_\_

Family Medical History: (Please circle any of the following that apply)  
Cancer      Diabetes      Heart Disease      Stroke      High Cholesterol  
High Blood Pressure      Asthma      Seizures      Other \_\_\_\_\_

Please circle any of the following that you have had:  
Cancer      Diabetes      Heart Disease      Stroke      High Cholesterol  
High BP      Asthma      Seizures      Anemia      Other \_\_\_\_\_  
Numbness      Dizziness      Irregular Heartbeat      Heartburn/Acid Reflux  
Digestive Problems      Bronchitis      Pneumonia      Anxiety      Depression  
Skin Problems      Insomnia      Headaches      Migraines  
Sexual Dysfunction      Menstrual Problems      Other \_\_\_\_\_

Do you have a pacemaker? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Please shade in areas of your discomfort if applicable:

