



VITAL LIFE CHIROPRACTIC

First Name _____ Middle _____ Last _____ Today's Date ____/____/____

Age _____ Male/Female _____ Date of Birth ____/____/____ SS# _____-____-_____

Address _____ City _____ State _____ ZIP _____

Phone: Home _____ Cell _____ Phone Provider _____

Email Address _____

Do you have Medicaid? Y / N (present your card to the front desk when complete) Do you have Medicare? Y / N

Appointment notification preference? Text / Email Notification prior to appointment? 1 day/ 2 days/ 2 hr./ 1 hr.

Occupation _____ Employer's Name _____ Are you a student? Y / N

Single/Married _____ Spouse's Name _____ # Children _____ Names, Ages, & Genders _____

Who may we thank for referring you into our practice? _____

PLEASE LIST YOUR HEALTH CONCERNS BELOW IN ORDER OF SEVERITY

Concern	Severity 1-10	Start Date	Prior Concern?	From Injury?	Constant/ Intermittent
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

What is this affecting that is MOST important in your life? (List all that apply)

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

Have you ever seen any other doctor for this condition? _____ Chiropractor _____ Medical Doctor _____ Other _____

If so, WHO & WHEN _____

List Surgeries & Date _____

List all MEDICATIONS you are currently taking _____

Have you had previous chiropractic care? Y / N If YES, when & who? _____

When was your last auto accident? _____ Have you ever been knocked unconscious? Y / N

Have you fractured any bones? Y / N If YES, please describe _____

Other traumas? Please describe _____

CIRCLE ANY OF THESE CONCERNS THAT YOU HAVE HAD IN THE PAST 2 YEARS

- | | | | |
|-----------------|-----------------|-------------------|---------------------|
| DIZZINESS | ASTHMA | KIDNEY PROBLEMS | CHRONIC FATIGUE |
| HEADACHES | ULCERS | BLADDER PROBLEMS | LUPUS |
| VERTIGO | CHEST PAINS | IRRITABLE BLADDER | FIBROMYALGIA |
| EAR INFECTIONS | ARMS NUMBNESS | SCIATICA | ADD/ADHD |
| GRATING OF NECK | ARM PAIN | LEG NUMBNESS | GERD |
| TMJ | HAND NUMBNESS | FEET NUMBNESS | ANXIETY |
| NECK PAIN | SHOULDER PAIN | LOW BACK PAIN | NERVOUSNESS |
| MIGRAINES | HEART DISORDERS | HIP PAIN | EPILEPSY |
| STIFF NECK | MID BACK PAIN | LEG PAINS | DISC PROBLEMS |
| CHRONIC SINUS | INFERTILITY | STOMACH DISORDERS | KNEE PAIN |
| THROAT ISSUES | NAUSEA | LIVER DISEASE | HIGH BLOOD PRESSURE |
| THYROID ISSUES | REFLUX | MENSTRUAL ISSUES | OTHER _____ |

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE-CANCER--SPINAL SURGERY OR FRACTURE-SEIZURES-SCOLIOSIS-DIABETES

HEALTH STATUS QUESTIONARE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Your Physical Life			
Presence of physical pain	1 2 3 4 5	Incidence of colds or flu	1 2 3 4 5
Feelings of tension, stiffness, lack of flexibility	1 2 3 4 5	Ability to work out or engage in activity	1 2 3 4 5
Incidence of fatigue or low energy	1 2 3 4 5	Incidence of chronic disease	1 2 3 4 5
Mental/Emotional State			
Presence of negative feelings/energy	1 2 3 4 5	Being overly worried about small things	1 2 3 4 5
Moodiness, temper, or angry outbursts	1 2 3 4 5	Difficulty thinking or concentrating	1 2 3 4 5
Difficulty falling or staying asleep	1 2 3 4 5	Feeling of depression or anxiety	1 2 3 4 5
Chemical/Nutritional Life			
Eat a well-balanced diet	1 2 3 4 5	Eat organic, grass fed, hormone free	1 2 3 4 5
Eat a diet rich in fruits and vegetables	1 2 3 4 5	Use a lot of chemicals on your skin	1 2 3 4 5
Eat fast food or highly processed food	1 2 3 4 5	Ingestion of chemicals	1 2 3 4 5
Stress Evaluation			
Family	1 2 3 4 5	Work/school	1 2 3 4 5
Significant relationship	1 2 3 4 5	Day-to-day stress	1 2 3 4 5
Health	1 2 3 4 5	Finances	1 2 3 4 5
Life Enjoyment			
Experiences of relaxation, ease, or well-being	1 2 3 4 5	Compassion and acceptance	1 2 3 4 5
Interest in maintaining a healthy lifestyle, diet etc.	1 2 3 4 5	The level of recreation in your life	1 2 3 4 5
Time devoted to things you enjoy	1 2 3 4 5	Your physical appearance	1 2 3 4 5

PLEASE WRITE DOWN 3 HEALTH GOALS.

1. _____
2. _____
3. _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

**I HAVE SUBMITTED INFORMATION ON THIS PAPERWORK TO THE BEST OF MY
KNOWLEDGE AS OF THE CURRENT DATE**

(Signature) (Date)

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is \$15.00. This fee must be paid in advance. The disc will be available within 72 hours of prepayment on any regular practice hours/days. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Vital Life Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below you are agreeing to the above Terms and Conditions.

(Print Name) (Signature) (Date)

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT VITAL LIFE CHIROPRACTIC.

(Signature) (Start Date of last menstruation)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

(Print Name)

(Signature) (Date)

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

(Signature of Guardian for Minor/Child) (Date) (Relationship)

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature) (Date)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

(Signature) (Date)