Whom may we thank for referring you to this office_____?

Vita Chiropractic Clinic

PATIENT APPLICATION

Today's Date:_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____ Age:_____ Sex: Male/Female

Address:_____ City:_____ State:_____ Zip:_____

E-mail Address:_____ Social Security #:_____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Do you have Insurance? Yes/ No, If Yes, Name of Insurance Company _____

Marital Status: Single/ Married Employer: _____ Occupation: _____
Spouse's Name _____Spouse's Employer_____

Number of children and Ages: _____
Name & Number of Emergency Contact: _____Relationship:_____

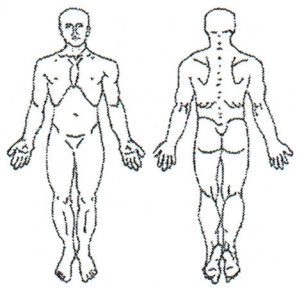
HISTORY of COMPLAINT Please identify the condition(s) that brought you to this office and on a scale of 1 to 10 with 10 being the worst pain and one being no pain, rate your above complaints by circling the number:

Primary or chief complaint is_____:0-1-2-3- 4-5-6-7-8-9-10

Second complaints is_____:0-1-2-3- 4-5-6-7-8-9-10

Third complaint is _____:0-1-2-3- 4-5-6-7-8-9-10

Fourth complaint is _____:0-1-2-3- 4-5-6-7-8-9-10



*PLEASE MARK the areas on the Diagram with the following letters to describe you symptoms: R =Radiating B =Burning D =Dull A= Aching N =Numbness S =Sharp Stabbing T= Tingling

Do you get headaches? Yes/ No If yes, how often? _____

When did the problem(s) begin? _____

When is the problem at its worst? AM / PM / mid-day / late PM

How long does it last? It is constant / I experience it on and off during the day / It comes and goes throughout the week

What aggravates your pain? Sit/Stand/Walking/Bending/Lift/Twist/Push/Pull/Driving/Movements
What relieves your pain? Recumbence/Medication/ Movement/ Rest/ Adjustment/ Massage
How did the injury happen? _____
What relieves your symptoms? _____
What makes them feel worse?_____
Condition(s) ever been treated by anyone in the past? No/Yes If yes, when:_____
by whom?_____ How long were you under care? _____
Name of Previous Chiropractor: _____

LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL: USUAL ACTIVITY LEVEL:

_____

_____

Is your problem the result of ANY type of accident? Yes / No If yes, date of accident: _____

Patients Name: _____ **Date:** _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No / Yes If yes, how many times? _____ Episode? _____ How did the injury happen? _____ _____ When was the last? _____

Other forms of treatment tried: No / Yes If yes, please state what type of treatment: _____ and who provided it? _____ how long ago? _____

what were the results? Favorable/ Unfavorable ,please explain

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have and N for Never have had: _Broken Bone _Dislocations /Heart Attack _OsteoArthritis _Tumors _Rheumatoid Arthritis _Diabetes _Stroke _Fracture _Disability _Cancer

Other serious conditions:_____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES: List:_____			
SURGERIES List:_____			
CHILDHOOD DISEASES List:_____			
ADULT DISEASES List:_____			

SOCIAL HISTORY

1. Smoking: cigars/ pipe / cigarettes Daily/ Weekends/ Occasionally / Never
2. Alcoholic Beverage: consumption occurs Daily/ Weekends/ Occasionally / Never
3. Recreational Drug use: How often? Daily/ Weekends/ Occasionally / Never
4. How does your present problem affect the following: Hobbies -Recreational Activities- Exercise Regime:

_____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? No / Yes

If yes whom: grandmother /grandfather /mother / father / sister's / brother's / son(s) / daughter(s) Have they ever been treated for their condition? No / Yes /I don't know

2. Any other hereditary conditions the doctor should be aware of No / Yes If yes, please explain

_____

I hereby authorize payment to be made directly to Vita Chiropractic Clinic , for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies there of for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Vita Chiropractic Clinic for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature Date Completed

_____ _____

Doctor's Signature Date Form Reviewed

Patients Name: _____ Date: _____

List Prescription & Non-Prescription medications you take:

_Pain Killers _ Muscle Relaxers _Blood pressure medication _Insulin

_Aspirin _Acetominophen _Ibuprofen

_Other/Over-the-counter_____

REGARDING: X-rays/Imaging Studies

FEMALES ONLY please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

Are you pregnant? _____ Are you nursing? _____

The first day of my last menstrual cycle was on_____ date

By my signature below I am acknowledging that the above information is correct. I understand the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signed: _____ Date: _____

Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- Our office offers open adjusting areas, by signing below I am agreeing to be taken care of in this manner.
- If I choose not to sign below I will be given a private room.

Print name of patient _____ Date _____

Signature of patient _____ Date _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____