Vitality Wellness Chiropractic

PERSONAL INFORMATION

Date:	
Name (Legal):	**Preferred Name:**
Address:	
City/State/Zip:	
Cell Phone: ( )	**E-mail:**
Date of Birth:	**Age:** **Sex: M F**
Occupation:	**Employer**
Marital Status:	**Spouse's Name:**
Who can we thank for referring you, or how did you hear about our office?	

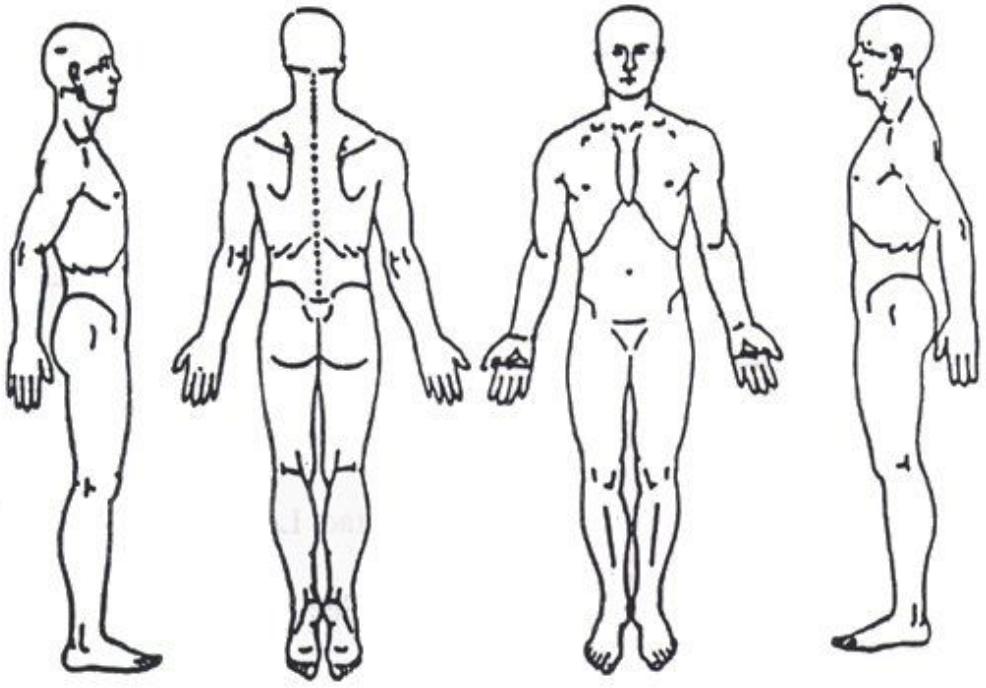
REASON FOR SEEKING CARE

Reason for seeking care at VWC?
When did this begin (if applicable)?
Are there any major injuries of which we should be aware?
Do you have illnesses, or had any in the past?
What is this affecting that is MOST important in your life? (List all that apply)
Have you seen any other providers for this condition? (List all that apply)
Have you seen a chiropractor before? (circle one) YES NO
If yes, how long ago? Clinic/Doctor Name:
What is your reason for change? (if applicable)
What is you level of commitment to yourself and your health? (1 = low commitment, 10 = strong commitment) **1 2 3 4 5 6 7 8 9 10** **Please explain:**
What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?
Please list any medications and supplements you are taking:

Please mark **area(s)** of injury or discomfort as show in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

Example



Check any of the following symptoms in which you have now (N) or in the past (P):

(N)	(P)	
____	____	Severe or frequent headaches
____	____	SInus infections or frequent colds
____	____	Asthma
____	____	Allergies
____	____	Loss of sleep or weight (circle one)
____	____	Loss of concentration
____	____	Depression
____	____	Nervousness/Anxiety
____	____	Tremors
____	____	Arthritis/Bursitis
____	____	Irritability
____	____	Dizziness
____	____	Acid reflux/difficult digestions
____	____	Constipation
____	____	Diarrhea
____	____	Anemia
____	____	Jaundice or liver trouble
____	____	Gallbladder trouble
____	____	Bed wetting
____	____	Painful or frequent urination
____	____	Itching or rashes

(N)	(P)	
____	____	Eczema or psoriasis
____	____	Deafness
____	____	Earache
____	____	Eye pain
____	____	Hay fever
____	____	High or Low blood pressure (circle one)
____	____	Rapid or Slow heartbeat (circle one)
____	____	Stroke
____	____	Swelling ankles
____	____	Chest pain
____	____	Chronic cough
____	____	Difficulty breathing or wheezing (circle one)
____	____	Nausea/Vomiting

WOMEN ONLY:

____	____	Cramps or backache during period
____	____	Excessive flow/discharge
____	____	Hot flashes
____	____	Irregular cycle/painful menses
____	____	Miscarriage

Are you pregnant? Yes No

TERMS OF ACCEPTANCE AND CONSENT TO CHIROPRACTIC SERVICES

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. **Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. **Health:** A state of optimal physical, mental, and social well-being, not merely the absence of infirmity. **Vertebral Subluxation** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by pothers. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom.

I hereby request and consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Suzanne Bowen. I will have an opportunity to discuss with Vitality Wellness Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to you to be fully informed before consenting treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Vitality Wellness Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Vitality Wellness Chiropractic responsible for any errors or omission that I may have made in the completion of this form.

Signature: _____ Date: _____

PATIENT HEALTH INFORMATION / HIPAA CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with out privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care,

I have read, or have had read to me, the full terms above of acceptance and consent to chiropractic services and have also had an opportunity to ask questions about its content. By signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff. I have also read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Vitality Wellness Chiropractic is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to maintain the privacy of your PHI and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your right as a patient under the law. You have the right to review our Notice before signing this Consent, and you are advised to do so.

By signing this form you consent to our use and disclosure to third parties of you PHI for treatment, payment, health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written and dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Signature: _____ Relationship to Patient:_____ Date: _____

PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and myself. And that Vitality Wellness Chiropractic does not take insurance. I clearly understand and agree that all services rendered to me are charged directly to me, and 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 to me will be immediately due and payable. In case of a pre-pay plan, payments made for services not utilized will be returned.

Signature: _____ Date: _____

X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

X-ray examination of the pelvis exposes the uterus to radiation. The last ten days following onset of menstrual cycle are generally considered safe for x-ray examination.

Date of onset of last menstrual period: _____

I am pregnant: Yes No (Circle one)

Signature: _____ Date: _____