VITALITY
FAMILY CHIROPRACTIC

Welcome to Vitality Family Chiropractic. Please fill this form out to the best of your ability, if there are any sections that do not apply, simply write N/A and move on to the next question.

Name: _____ Date of Birth: _____ Age: ____

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

Phone: (H)_____(W)_____(C)_____ Email: _____

Occupation: _____ Employer: _____ Marital Status: ❑S ❑ M ❑ D ❑W

Spouse's Name: _____Spouse's Occupation: _____

Emergency Contact - Name: _____ Relationship: _____ Phone: _____

Referred By: ❑Facebook Ad ❑Instagram ❑Google ❑Family/Friend (Name): _____

Number of Children and Ages **Previous Chiropractic Care?**

Name: _____ Age: _____ Yes___ No___ Reason _____

Name: _____ Age: _____ Yes___ No___ Reason _____

Name: _____ Age: _____ Yes___ No___ Reason _____

Name: _____ Age: _____ Yes___ No___ Reason _____

LIST YOUR HEALTH CONCERNS BELOW

	Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.						
2.						
3.						
4.						
5.						

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? _____ MEDICAL DOCTOR? _____OTHER_____

WHO AND WHEN? _____

CIRCLE ALL CONDITIONS YOU HAVE OR HAVE HAD:

DIZZINESS	*DEPRESSION*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*AUTOIMMUNE DISEASE*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*EENT*	*SCIATICA*	*RINGING IN THE EARS*	*INFERTILITY*
NAUSEA	*NUMBNESS/TINGLING*	*SENSITIVITY TO LIGHT*	*FIBROMYALGIA*	*GASTRIC REFLUX*
TMJ	*PROSTATE ISSUES*	*SENSITIVITY TO SOUND*	*CHEST PAIN*	*ALLERGIES*
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*SLEEPING DIFFICULTIES*
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	*OTHER: _____*
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*	*JOINT PAIN*	
IRRITABILITY	*BLADDER PROBLEMS*	*KNEE PAIN*	*HIGH BLOOD PRESSURE*	
LOSS OF MEMORY	*LOSS OF TASTE*	*HEART BURN*	*CHRONIC SINUS*	
LOSS OF SMELL	*LOSS OF BALANCE*	*SHORTNESS OF BREATH*	*CONSTIPATION/DIARRHEA*	

CIRCLE YOUR TOP 3 HEALTH GOALS

LESS/NO PAIN	INCREASED PRODUCTIVITY	MOTIVATION
LESS/NO MEDICATIONS	ABILITY TO ENJOY HOBBIES	BETTER DIGESTION
PREVENT SURGERY	SPEND TIME WITH FAMILY	INCREASED STRENGTH
INCREASED LONGEVITY	INCREASED ENERGY	INCREASED MOBILITY
LESS ANXIETY	BETTER SLEEP	WELLNESS

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD **(IF NOTHING APPLIES PLEASE WRITE N/A HERE_____)**

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL PROCEDURES AND WHEN_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____

_____

HAVE YOU BEEN IN AN AUTO ACCIDENT? YES / NO *IF YES, WHEN?*_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO *IF YES, WHEN?*_____

***REASON*_____CHIROPRACTOR'S NAME_____**

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:_____

HOW WOULD YOU RATE YOUR OVERALL QUALITY OF LIFE (CIRCLE ONE)

EXCELLENT GOOD AVERAGE FAIR POOR

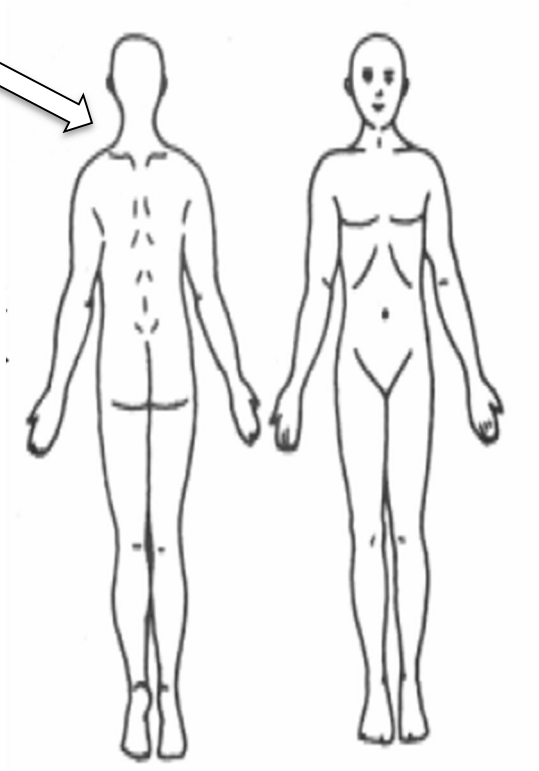
<u>WHAT</u> ARE YOU CURRENTLY DOING FOR YOUR HEALTH_____

<u>WHAT</u> DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH CONDITION(S)

_____

*__<u>PLEASE MARK</u>__ the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness
S = Sharp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

<u>SOCIAL HISTORY</u>

1. **<u>SMOKING:</u> ❑ YES ❑ NO**
   ❑ CIGARS ❑ PIPE ❑ CIGARETTES ❑ VAPE
   HOW OFTEN? ❑ DAILY ❑ WEEKENDS ❑ OCCASIONALLY

2. **<u>CONSUME ALCOHOL:</u> ❑ YES ❑ NO**
   HOW OFTEN? ❑ DAILY ❑ WEEKENDS ❑ OCCASIONALLY

3. **<u>EXERCISE</u>: ❑ YES ❑ NO**
   HOW OFTEN? ❑ 1-2X/WEEK ❑ 3-4X/WEEK ❑ 5X OR MORE/WEEK ❑ OCCASSIONALLY

<u>FEMALE HISTORY</u>

Please list your # of Pregnancies: _____ Vaginal Deliveries: _____ Cesarean Surgery: _____ Miscarriages: _____

Deliveries were at ❑Home ❑Birth Center ❑Hospital ❑Other: _____

Have you ever taken or currently taking birth control? ❑Yes ❑No

Have you ever had infertility issues? ❑Yes ❑No Date of last menstrual cycle: _____

<u>MALE HISTORY</u>

Have you ever experienced infertility issues with your spouse? ❑Yes ❑No Date of last prostate exam: _____

Erectile dysfunction? ❑Yes ❑No Difficulty/pain during urination? ❑Yes ❑No

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.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.
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 DOCTORS OF OZNER FAMILY CHIROPRACTIC DO 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 YOUR NAME HERE **DATE**

_____ _____
SIGNATURE **YOUR AGE**

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

_____ _____
SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____
_____

CA Initials:
_____

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 though 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 Acknowledgement

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 to 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)**

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 PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. KATHERYNE CASTRO AND ANY AND ALL VITALITY FAMILY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY VITALITY FAMILY CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR / CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEART DISEASE					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

VITALITY
FAMILY CHIROPRACTIC

Authorization Form

Patient Name:_____
Address:_____City:_____State:_____
Phone Number:_____-_____-_____ Email:_____
THE PATIENT ABOVE AUTHORIZES VITALITY FAMILY CHIROPRACTIC, LLC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

____ Yes / No I give Vitality Family Chiropractic, LLC permission to leave messages regarding appointments, finances, and other office concerns via phone call, voicemail, text or email. Vitality Family Chiropractic, LLC may also leave messages or discuss my care with the following family member or other:_____

____Yes / No I give Vitality Family Chiropractic, LLC permission to provide care for me in an open room where other patients are also being cared for. I am aware that other person(s) in the office may overhear some of my protected health information during my care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for these conversations.

____ Yes / No I give Vitality Family Chiropractic, LLC permission to use my name and/or picture on office picture boards, testimonials, thank you boards, referral boards and social media sites.

____ Yes / No I give Vitality Family Chiropractic, LLC permission to use and disclose to other Healthcare Practitioners, Health Insurance Companies and attorneys my protected health information and in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATIONS

You have the right to revoke this authorization, in writing, at any time. You may revoke this authorization by mailing or hand delivering a written notice to Vitality Family Chiropractic, LLC. The written notice must contain the following information:

- Your name and date of birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your signature

The revocation will be effective on the date Vitality Family Chiropractic, LLC receives it. You have a right to refuse to sign this authorization. If you refuse to sign this authorization, Vitality Family Chiropractic will not refuse to provide care.

_____ _____
Print Patient Name Date

_____
Signature of Patient or Representative or Legal Guardian