

# VITA CHIROPRACTIC INTAKE & HEALTH HISTORY

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered

Employer / School \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Children Name, ages, and gender: \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Contact Number \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_

## IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0  1  2  3  4  5  6  7  8  9  10  
 NOT COMMITTED VERY COMMITTED

## HOW CAN WE HELP YOU?

What brings you in today?

\_\_\_\_\_

If you are already experiencing a symptom, what is it? \_\_\_\_\_

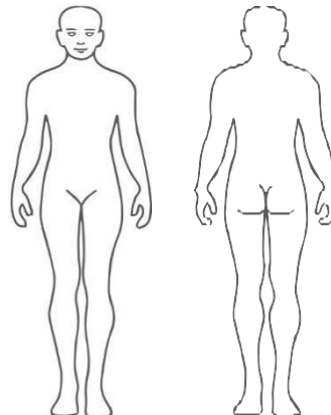
How bad is it? How intense are your symptoms? (circle)

0  1  2  3  4  5  6  7  8  9  10  
 NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Sharp       |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Shooting    |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning     |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Throbbing   |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Stabbing    |
| <input type="checkbox"/> Cramping  | <input type="checkbox"/> Swelling    |
| <input type="checkbox"/> Nagging   | <input type="checkbox"/> Other _____ |



## PATIENT WELLNESS ASSESSMENT

### ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? \_\_\_\_\_

B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONGTERM \_\_\_\_\_

## ACCIDENTS & TRAUMAS

List all surgical operations and years \_\_\_\_\_

Have you ever been in an auto accident? List all: \_\_\_\_\_

List any other injuries to your spine, minor or major \_\_\_\_\_

Have you ever been knocked unconscious? Please circle. Yes No

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues                                   | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness                                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Scoliosis       |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hip Issues            | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Digestive Issues<br>(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues         | <input type="checkbox"/> TMJ Issues      |
| <input type="checkbox"/> Asthma/Allergies      | <input type="checkbox"/> Elbow/Wrist/Hand Issues                              | <input type="checkbox"/> Lymphatic Issues      | <input type="checkbox"/> Urinary Issues  |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Endocrine Issues (Thyroid)                           | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues                                    | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Gout   | <input type="checkbox"/> Reproductive Issues   |  |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SUPPLEMENTS (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# 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: SPRAINS/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 HERE

\_\_\_\_\_  
SIGNATURE OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

***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. ZACH NELSON AND ANY AND ALL VITA 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 VITA CHIROPRACTIC.

\_\_\_\_\_  
GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE (OFFICE STAFF)

\_\_\_\_\_  
DATE

## TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimal 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 process.
- 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 by 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 need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility or 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 or 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.*

\_\_\_\_\_  
PRINT NAME HERE

\_\_\_\_\_  
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 physician's 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 disclose 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.

\_\_\_\_\_  
PRINT NAME HERE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

File#: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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 DOCTOR OF VITA 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 HERE**

\_\_\_\_\_  
**DATE OF BIRTH**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

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

**SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_**

**-- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE --**

<input type="checkbox"/> Lat Cervical CM    Kvp    Time    MAS <input type="checkbox"/> 10-11 <input type="checkbox"/> 78 <input type="checkbox"/> 1/24   12.5 <input type="checkbox"/> 12-13 <input type="checkbox"/> <input type="checkbox"/> 1/20   15 <input type="checkbox"/> 14-15 <input type="checkbox"/> 1/15   20 <input type="checkbox"/> 16-17 <input type="checkbox"/> 1/10   30 <input type="checkbox"/> 2/15   40 MA 300    Size 8x10	<input type="checkbox"/> Flex/Ext Time    MAS <input type="checkbox"/> 1/24   12.5 <input type="checkbox"/> 1/20   15 <input type="checkbox"/> 1/15   20 <input type="checkbox"/> 1/10   30 <input type="checkbox"/> 2/15   40	<input type="checkbox"/> Lower Cervical CM    Kvp    Time    MAS <input type="checkbox"/> 14-15 <input type="checkbox"/> 70 <input type="checkbox"/> 1/10   20 <input type="checkbox"/> 16-17 <input type="checkbox"/> <input type="checkbox"/> 2/15   30 <input type="checkbox"/> 18-19 <input type="checkbox"/> 3/20   40 <input type="checkbox"/> 20-21 <input type="checkbox"/> 2/10   50 <input type="checkbox"/> 22-23 MA 300    Size 8x10	<input type="checkbox"/> Lateral Thoracic CM    Kvp    Time    MAS <input type="checkbox"/> 22-23 <input type="checkbox"/> 80 <input type="checkbox"/> 1/15   20 <input type="checkbox"/> 24-25 <input type="checkbox"/> <input type="checkbox"/> 1/10   30 <input type="checkbox"/> 26-27 <input type="checkbox"/> 2/15   40 <input type="checkbox"/> 28-29 <input type="checkbox"/> 2/10   50 <input type="checkbox"/> 30-31 <input type="checkbox"/> 1/4    75 <input type="checkbox"/> 32-33 <input type="checkbox"/> 3/10   90 <input type="checkbox"/> 34-35 <input type="checkbox"/> 2/5    120 <input type="checkbox"/> 36-37 <input type="checkbox"/> 1/2    150 MHA 300    Size 14x17	<input type="checkbox"/> A-P Thoracic CM    Kvp    Time    MAS <input type="checkbox"/> 16-17 <input type="checkbox"/> 75 <input type="checkbox"/> 1/20   17 <input type="checkbox"/> 18-19 <input type="checkbox"/> <input type="checkbox"/> 1/15   22 <input type="checkbox"/> 20-21 <input type="checkbox"/> 1/10   30 <input type="checkbox"/> 22-23 <input type="checkbox"/> 2/15   40 <input type="checkbox"/> 24-25 <input type="checkbox"/> 2/10   50 <input type="checkbox"/> 26-27 <input type="checkbox"/> 1/4    75 <input type="checkbox"/> 28-29 <input type="checkbox"/> 3/10   90 <input type="checkbox"/> 30-31 <input type="checkbox"/> 2/5    120 MA 300    Size 14x17	
<input type="checkbox"/> APOM CM    Kvp    Time    MAS <input type="checkbox"/> 14-15 <input type="checkbox"/> 70 <input type="checkbox"/> 1/10   20 <input type="checkbox"/> 16-17 <input type="checkbox"/> <input type="checkbox"/> 2/15   30 <input type="checkbox"/> 18-19 <input type="checkbox"/> 3/20   40 <input type="checkbox"/> 20-21 <input type="checkbox"/> 2/10   50 <input type="checkbox"/> 22-23 MA 300    Size 8x10	Other View _____  CM _____ Kvp _____  MAS _____ MA _____  Size _____		<input type="checkbox"/> Lateral Lumbar CM    Kvp    Time    MAS <input type="checkbox"/> 26-27 <input type="checkbox"/> 88 <input type="checkbox"/> 2/10   30 <input type="checkbox"/> 28-29 <input type="checkbox"/> 90 <input type="checkbox"/> 1/4    40 <input type="checkbox"/> 30-31 <input type="checkbox"/> 92 <input type="checkbox"/> 3/10   50 <input type="checkbox"/> 32-33 <input type="checkbox"/> 94 <input type="checkbox"/> 2/5    70 <input type="checkbox"/> 34-35 <input type="checkbox"/> 96 <input type="checkbox"/> 1/2    90 <input type="checkbox"/> 36-37 <input type="checkbox"/> <input type="checkbox"/> 3/5    120 <input type="checkbox"/> 38-39 <input type="checkbox"/> 4/5    160 <input type="checkbox"/> 40-41 <input type="checkbox"/> 1    200 <input type="checkbox"/> 42-43 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> 2 MA 200    Size 14x17	<input type="checkbox"/> A-P Lumbar CM    Kvp    Time    MAS <input type="checkbox"/> 20-21 <input type="checkbox"/> 76 <input type="checkbox"/> 1/15   40 <input type="checkbox"/> 22-23 <input type="checkbox"/> 78 <input type="checkbox"/> 1/10   50 <input type="checkbox"/> 24-25 <input type="checkbox"/> 80 <input type="checkbox"/> 2/15   75 <input type="checkbox"/> 26-27 <input type="checkbox"/> <input type="checkbox"/> 2/10   90 <input type="checkbox"/> 28-29 <input type="checkbox"/> 1/4    120 <input type="checkbox"/> 30-31 <input type="checkbox"/> 3/10   150 <input type="checkbox"/> 32-33 <input type="checkbox"/> 2/5    120 <input type="checkbox"/> 34-35 <input type="checkbox"/> 1/2    170 <input type="checkbox"/> 36-37 <input type="checkbox"/> 3/5    210 <input type="checkbox"/> 38-39 <input type="checkbox"/> 4/5 <input type="checkbox"/> 40-41 <input type="checkbox"/> 1 <input type="checkbox"/> 42-43 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> 2 MA 300    Size 14x17	
Sex: M / F  NOTES: _____ _____ _____ _____ _____					