VITA CHIROPRACTIC AUTOMOBILE/PERSONAL INJURY/WORKMANS COMP PROFILE

Name: _____ Date of Birth: _____ /_____ /_____ Age: _____Male ☐ Female ☐

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

Cell phone: _____ Home phone: _____ Email Address:_____

Occupation:_____ Employer: _____ Pregnant?: Yes ☐ No ☐

Single ☐ Married☐ Divorced ☐ Widowed ☐ Spouse's Name_____ # of Children:_____

Names, Ages, & gender: _____

Who may we thank for referring you? _____

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you.

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

___ Headaches	___ Buzzing in Ears	___ Upset Stomach	___ Light Bothers Eyes
___ Neck Pain	___ Memory Loss	___ Depression	___ Head Seems too Heavy
___ Neck Stiff	___ Ears Ring	___ Feet Cold	___ Pins & Needles in Arms/Hands
___ Dizziness	___ Loss of Taste	___ Hands Cold	___ Pins & Needles in Legs/Feet
___ Upper Back Pain	___ Loss of Smell	___ Face Flushed	___ Numbness in Arms/fingers
___ Low Back Pain	___ Chest Pain ___ Fainting	___ Numbness in Legs/toes	
___ Hip/Leg Pain	___ Nervousness	___ Loss of Balance	___ Sleeping Problems
___ Tension	___ Diarrhea	___ Fever	___ Irritability
___ Fatigue	___ Constipation	___ Cold Sweats	___ Shortness of Breath

Symptoms other than above: _____

_____

Did you have any symptoms before the accident, including or in addition to above? Please List: _____

_____

Have you lost time from work as a result of this accident? Yes or No **If yes, please explain:** _____

_____

Before the injury were you capable of working on an equal basis with others your age? Yes or No

NATURE OF INJURIES:

Please explain in detail how your accident happened: _____

_____

_____

Date of Accident/Injury: _____ **Time of Day:** _____

Vita Chiropractic Doctor Signature: _____ Reviewed on: ____/____/_____

Where did you feel pain immediately after the accident?: _____

Later that day?: _____ The next day?: _____

List the extent of any injuries as you know them: _____

_____

Where were you taken after the accident?: _____

Were the police notified? Yes or No **Were you knocked unconscious?** Yes or No **If yes, How Long?:**_____

Hospitalized? Yes or No **If yes, admitted?:**_____ **How Long?:**_____

Name of Hospital: _____

Name of Doctor(s): _____

Was treatment given?: _____

Were any other doctor(s) consulted after your accident? Yes or No **If yes, Doctor's Name?:**_____

What was the diagnosis: _____

How often did you see the doctor?_____ How Long did you see the doctor?:_____

Since this injury are your symptoms(Circle One): IMPROVING SAME WORSE

Mark any activities of daily living that have become restricted as a result of this injury:

0: No Restriction **1:** Slightly Restricted **2:** Mild Restriction **3:** Moderate Restriction **4:** Much Restriction **5:** Completely Restricted

___ Sleep	___ Lifting	___ Climbing Stairs	___ Carrying/Lifting Groceries	___ Shaving
___ Pet Care	___ Walking	___ Static Sitting	___ Sitting to Standing	___ Driving
___ Yard Work	___ Dishes	___ Static Standing	___ Extended Computer Use	___ Garbage
___ Laundry	___ Dressing	___ Sexual activities	___ Reading/Concentration	___ Bathing
___ Sweeping/Vacuuming		Other _____	Other _____	Other _____

PLEASE MARK the areas on the diagram with the following LETTER(S) to describe your symptoms:

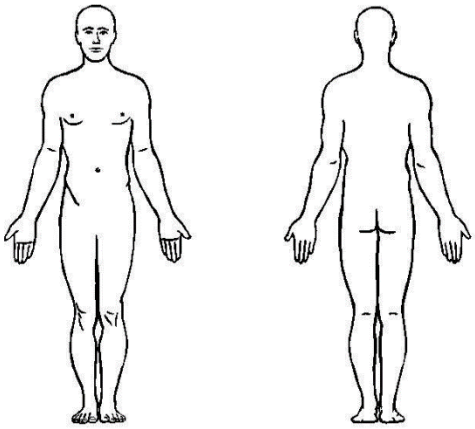
R= Radiating **B= B**urning **D=** Dull **A=** Aching

S=Sharp/Stabbing **N=** Numbness **T=**Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

When is (are) the problem(s) at its worst? AM PM Mid-Day Late PM



NATURE OF ACCIDENT: QUESTIONAIRE

1. **Date of Accident:** _____ **Time of Day:**_____
2. **Where you were in the vehicle:** DRIVER or PASSENGER
   FRONT—BACK SEAT DRIVER SIDE—CENTER—BACK SEAT PASSENGER SIDE
3. **Does your car have a headrest?** YES or NO **If yes, what were the settings?** Bottom of Neck / Bottom of Head / Middle of Head
4. **Number of people in vehicle:** ____ **Were you wearing a seatbelt?:** YES or NO
5. **Were you struck from:** Behind / Front / Left Side / Right Side
6. **Speed of your car?** _____ mph / **Other Car:** _____mph
7. **Were you knocked unconscious?** YES or NO If yes, How Long: _____
8. **Were police notified?** YES or NO If yes, Police Report #: _____

Vita Chiropractic Doctor Signature: _____ Reviewed on: ____/____/_____

9. **Kind of Car you were driving: Model:**_____ **Make:**_____ **Year:**_____
10. **How much damage to your car $:**_____
11. **In your own words please describe the accident:**_____
    _____
    _____
12. **Did you have any physical complains BEFORE THE ACCIDENT?** YES or NO If Yes, Please Describe: _____
    _____
13. **Please describe how you felt: During the accident:** _____
    Immediately after the accident: _____
    Later that day:_____ **The next day after the accident:**_____
14. **Where were you taken after the accident?:**_____
    What type of treatment did you receive:_____
15. **What other doctors have TREATED you SINCE the accident?:**_____
16. **Since this injury are your symptoms(Circle One):** IMPROVING GETTING WORSE SAME
17. **Have you lost time from work as a result of this accident?** YES or NO If yes, Please Explain: _____
18. **Have you noticed any activity restrictions as a result of this accident?** YES or NO
    If yes, Please Explain: _____
    _____
    _

INSURANCE COMPANY WITH WHOM CLAIM IS BEING FILED: _____

Insurance Adjuster Name: _____
Ins Adjuster Phone #: _____
Claim #: _____
Policy #: _____
Primary Policy Holder: _____

Driver of vehicle at fault: _____ **Insurance Co:** _____ **Policy#:**_____

Driver of vehicle in which you were injured:_____ **Insurance Co:** _____ **Policy#:**_____

Your Auto Insurance Company: _____ **Insurance Adjuster Name:** _____

Policy #:_____ **Insurance Adjuster Phone #:** _____

Primary Policy Holder: _____ **Claim #:** _____

IF YOU HAVE RETAINED AN ATTORNEY:

Attorney's Name: _____ Attorney's Phone Number: _____
Office Name: _____
Address: _____ City: _____ State:_____ Zip:_____

The above information is complete and correct to the best of my knowledge. I understand that this information is confidential and is only being asked of me to help determine if chiropractic care through Vita Chiropractic would be beneficial. If it is in the doctor's opinion that he believes I will not respond satisfactorily, Vita Chiropractic will not accept my case.

_____ _____
PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE DATE

ACTIVITIES OF DAILY LIVING ASSESSMENT

Rate your current difficulties, resulting from your accident/illness with regard to the various activities listed below. **Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty**.

1= "I can do it without any difficulty." **2=** "I can do it without much difficulty." **3=** "I manage to do it by myself, despite marked pain"

4= "I manage to do it, despite the pain, but only if I have help", **5=** "I cannot do it at all because of the pain" **Only fill in areas affected.**

Difficulties with Self-Care and Personal Hygiene Activities

__ Bathing	__ Drying Hair	__ Brushing Teeth	__ Putting on Shoes	__ Tying Shoes
__ Preparing Meals	__ Showering	__ Combing Hair	__ Making Bed	__ Eating
__ Doing Laundry	__ Washing Hair	__ Washing Face	__ Putting on pants	__ Cleaning Dishes
__ Going to the restroom				

Difficulties with Physical Activities

__ Standing	__ Walking	__ Kneeling	__ Reaching	__ Twisting Left
__ Twisting Left	__ Stooping	__ Leaning Back	__ Leaning Forward	__ Leaning Left
__ Leaning Right	__ Bending Left	__ Bending Right	__ Bending Back	__ Bending Forward
__ Reclining	__ Squatting	__ Standing for Long periods	__ Sitting for Long Periods	__ Walking long Periods
__ Kneeling for Long periods				

Difficulties with Functional Activities

__ Carrying Small Objects	__ Carrying Large Objects	__ Carrying Brief Case	__ Carrying Large Purse
__ Lifting Weights off Floor	__ Lifting Weights off Table	__ Climbing Stairs	__ Climbing Inclines
__ Pushing things while seated	__ Pushing things while standing	__ Pulling things while seated	__ Exercising Arms
__ Pulling Things While Standing	__ Exercising upper body	__ Exercising Lower Body	__ Exercising Legs

Difficulties with Social and Recreational Activities

__ Bowling	__ Jogging	__ Swimming	__ Ice Skating	__ Competitive Sports
__ Dating	__ Golfing	__ Dancing	__ Skiing	__ Roller Skating
__ Hobbies	__ Dining out			

Difficulties with Traveling

__ Driving in a Motor Vehicle	__ Driving for long periods of time
__ Riding as a Passenger	__ Riding as a passenger on an airplane
__ Riding as a passenger on a train	__ Riding as a passenger for long periods

Use the following 1 to 5 scale to describe the difficulties below:

1= "This area is NOT affected by my condition." **2=** "This area is SLIGHTLY affected by my condition."

3= "My condition MODERATELY RESTRICTS my ability in this area" **4=** "My condition SERIOUSLY LIMITS my ability in this area",

5= "My condition PREVENTS me from using this ability"

Difficulties with Different Forms of Communication

__ Concentrating	__ Hearing	__ Listening	__ Speaking
__ Reading	__ Writing	__ Using a Keyboard	

Difficulties with the Senses

__ Seeing __ Hearing __ Touch __ Taste __ Smell

Difficulties with Hand Functions

__ Grasping __ Holding __ Pinching __ Percussive movements
__ Sensory Discrimination

Difficulties with Sleep and Sexual Functions

__ Able to have normal, restful nights sleep __ Able to participate in desired sexual activities

Write in below any additional information regarding your Activities of Daily Living affected (that wasn't covered above):

_____

_____

Vita Chiropractic Doctor Signature: _____ Reviewed on: ____/____/_____

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain Back pain Headaches Worst possible pain

0 1 2 3 4 5 (6) 7 8 (9) 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____

FOR OFFICE USE: Q1_____+ Q2_____+ Q4_____=_____/3x10=_____

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 OCCURING 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 IF 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

_____ _____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE DATE

Vita Chiropractic Doctor Signature: _____ Reviewed on: ____/____/_____

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**

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 (HIPPA). 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.

_____ _____

SIGNATURE **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.

_____ _____

SIGNATURE **DATE**

PERSONAL INJURY PATIENT-PROVIDER CONTRACT AND PROMISSORY NOTE

Entered this day between Dr. Zachary Nelson (Hereinafter 'Provider') and _____ (Practice Member Name), (Hereinafter 'Patient'). Provider hereby agrees to establish an active account for the patient and to provide essential services for the purposes of benefitting and improving the Patient's current health condition. Patient agrees to pay Provider in full for services performed by Provider. Patient and Provider acknowledge that Patient retains any and all rights of suit to procure payment for and benefit Patient may be entitled. It is further acknowledged by both parties that this document does not create an express or implied assignment of benefits from any liability insurance carrier, Patient representative, or from Patient to Provider.

In consideration of and for Provider rendering essential chiropractic or medical services to Patient, and for the temporary suspension of any collection activity by Provider by the maintenance of a active account while not receiving payment at the point of service. Patient hereby authorizes and directs the following actions be taken on the Patient's behalf.

I. PATIENT AUTHORIZATION TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Patient by Provider that Patient and Provider are privy of contact, and in lien of Provider sending direct billing to liability insurance carrier Patient authorizes and directs liability insurance company to disclose the settlement status of Patient claim to Provider upon request, including settlement amounts thereof. After such time that Patient has settled the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Patient directs the liability carrier to include the name of the Provider on any check to Patient after such settlement. In the event payment is made to Patient attorney after settlement of claim, Patient further authorizes and directs the liability company to issue check to Provider for the full amount owed for chiropractic and/or medical services rendered to fully satisfy Patient's obligation to Provider.

II. PATIENT AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If patient hires an attorney; Patient acknowledges that Patient is represented by _____ , Attorney at Law. Patient and Provider stipulates, that representation by the above named attorney prior to settlement, judgement, or verdict in the Patient's claim. Provider shall have the option to terminate this agreement and immediately collect from Patient the full amount then owed to the Provider. Patient directs attorney to disclose to Provider upon request the settlement status and amount of Patient claim to include amount of all outstanding medical bills, dollar amount of any offers and counter offers as well as date and reason of termination or dismissal, Patient's last address, telephone number, and place of employment known to attorney. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement, judgement, or verdict rendered in Patient's claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider. This agreement survives this attorney-client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: In the event liability, insurance carrier or Patient's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing with Patient's attorney the likely representative for Patient.

IV. PROMISORY NOTE: For the consideration stated above, Patient promises to pay Provider the full balance in Patient's account for services rendered to Patient. Payment shall be due and payable within 120 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by Patient and treated by Provider whichever event occurs first, provided agreement has not been terminated by parties prior to these events in which case the account balance will be due in full 3 (three) days after termination. Further Patient agrees to the following:

> IN THE EVENT PATIENT'S ACCOUNT IS NOT PAID IN FULL WITHIN 120 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENT'S ACCOUNT WILL BECOME DELIQUINT. IF PATIENT'S ACCOUNT BECOMES DELIQUINT, PATIENT AGREES TO PAY COLLECTION AGENCY FEES AT 40% OF THE PATIENT ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICE. THE COLLECTION FEE WILL BE 40% OF THE ACCOUNT BALANCE IN ADDITION TO THE PATIENT BALANCE. PATIENT FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFECTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is agreed that, in the event Patient terminates this agreement, Patient shall pay full balance of Patient's account within 3 (Three) days of termination or the account shall be in default. Patient and Provider acknowledge that this document contains full, final, and entire agreement between both parties. There are no other terms to this agreement. Patient has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void it is expressly agreed by the parties that all remaining provision shall remain in full force.

Date of Agreement: _____

_____ _____

PATIENT NAME PATIENT SIGNATURE OR LEGAL GUARDIAN (IF A MINOR OR POA)

_____ _____

PROVIDER SIGNATURE WITNESS

Vita Chiropractic Doctor Signature: _____ Reviewed on: ____/____/_____

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 --

☐ 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 _____

Sex: M / F

NOTES: _____
_____
_____
_____
_____
_____

☐ 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

MHA 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

CA Initials: _____

☐ 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

☐ 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

Vita Chiropractic Doctor Signature: _____ Reviewed on: ____/____/_____

FAMILY HEALTH HISTORY

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

_____ _____

PLEASE PRINT NAME HERE **DATE**

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
HEADACHES					
NECK PAIN					
JAW PAIN/TMJ					
SHOULDER PAIN					
BACK PAIN					
HIP/LEG PAIN					
ARTHRITIS/JOINT PAIN					
EAR INFECTIONS					
HEARING LOSS					
DIZZINESS					
LOSS OF ENERGY					
NERVOUSNESS					
BLURRED/DOUBLE VISION					
ANXIETY					
ADD/ADHD					
DEPRESSION					
ALLERGIES					
SINUS ISSUES					
THYROID PROBLEMS					
ASTHMA					
BREATHING PROBLEMS					
HEART PROBLEMS					
HIGH/LOW BLOOD PRESSURE					
STOMACH PROBLEMS					
BED WETTING					
INFERTILITY					
SCIATICA					
FIBROMYALGIA					
POOR POSTURE					
SLEEP PROBLEMS					
STROKE					
CANCER					
HEART DISEASE					
DIABETES					
ARTHRITIS					
ALZHEIMERS					