



# Terms of Acceptance

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When a member of Vital Chiropractic Center seeks chiropractic health care and we accept a member 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 member understands 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 hand delivered forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra of 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 advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care 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 others. Our only practice is to eliminate a major interference to the expression of the nerve impulse. Our only method is the specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
( print name )

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## Children's Case History

Child's  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parents'  
Names \_\_\_\_\_

Parent's  
Phone \_\_\_\_\_ Work# \_\_\_\_\_

Siblings and ages \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

### CAUSE

*The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.*

*From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.*

*This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.*

## Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic? \_\_\_\_\_
2. Who? \_\_\_\_\_ Were x-rays taken? \_\_\_\_\_.
3. Who is your regular pediatrician? \_\_\_\_\_

Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage and even death to the infant.

Did you have ultrasound during this pregnancy? \_\_\_\_\_ Frequency \_\_\_\_\_

- Place of birth: Home/ Birthing Center/ Hospital .
- Provider: Midwife/ OB-Gyn/ Other \_\_\_\_\_
- Type of Birth: Vaginal / C-section. Was anesthesia used? \_\_\_\_\_  
Type \_\_\_\_\_
- Was labor induced? \_\_\_\_\_ If yes, why? \_\_\_\_\_
- What position did you deliver in: Squatting/ On Back
- Birth Trauma: Doctor assisted/ Twisting, Pulling/ Vacuum Extraction/ Forceps
- Newborn trauma ( medical procedures and tests) \_\_\_\_\_

Did you breast-feed your child? \_\_\_\_yes \_\_\_\_ no. How long? \_\_\_\_\_

Was your decision supported by your health care provider? \_\_\_\_yes \_\_\_\_no.

Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child? \_\_\_\_ Please Describe: \_\_\_\_\_

Any fractures or dislocations? \_\_\_\_\_

Which sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/  
Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Other \_\_\_\_\_.

Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? \_\_\_\_yes \_\_\_\_no. Is it in front of a computer or TV? \_\_\_\_\_

How would you rate your child's diet? \_\_\_\_\_

Does your child consume artificial sweeteners? \_\_\_\_\_ Flouridated water? \_\_\_\_\_

Circle any of the following conditions your child has suffered from :

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Other \_\_\_\_\_

How often has your child been treated with drugs ? \_\_\_\_\_

Were you informed of their adverse reactions ? \_\_\_\_yes \_\_\_\_ no

If it was an antibiotic, was your child cultured for its use? \_\_\_\_\_  
Is your child currently on any medications? (please list) \_\_\_\_\_

Any surgeries? \_\_\_\_\_

The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child? Did your child experience any behavioral, emotional or physical changes within 3 months after any shots? \_\_\_\_\_ Describe \_\_\_\_\_  
Was it reported by you or your doctor? \_\_\_\_\_

### Correction

*Today, we are becoming more aware, how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.*

*Current scientific research is showing the direct relationship between the function of the nervous system and the immune system function. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.*

*Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.*

### AUTHORIZATION FOR CARE OF A MINOR

I hereby Authorize Dr. \_\_\_\_\_ to administer care as deemed necessary to my son/daughter.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witnessed \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO TAKE AND PUBLISH PHOTOGRAPHS**

I, \_\_\_\_\_, authorize Dr. \_\_\_\_\_ or another person authorized by him/her to take and publish photographs of my child, \_\_\_\_\_, for clinical records. Such photographs may be used in publications for the purpose of scientific and /or clinical research, chiropractic education, and the promotion of chiropractic health care when the above named Doctor deems such publication will benefit these goals.

I also understand I will not be identified by name without additional authorization.

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_

WITNESS: \_\_\_\_\_

**form-p-005 Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information by **Vital Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Vital Chiropractic**.

I understand that diagnosis or treatment of me by **Vital Chiropractic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Vital Chiropractic** is not required to agree to the restrictions that I may request. However, if **Vital Chiropractic** agrees to a restriction that I request, the restriction is binding on **Vital Chiropractic** and **Vital Chiropractic**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Vital Chiropractic** or **Vital Chiropractic** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Vital Chiropractic's** Notice of Privacy Practices prior to signing this document.

The **Vital Chiropractic's** Notice of Privacy Practices has been made available to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my care, payment of my bills or in the performance of health care operations of the **Vital Chiropractic**.

The Notice of Privacy Practices for **Vital Chiropractic** is also provided and displayed in the reception area along the north wall.

This Notice of Privacy Practices also describes my rights and the duties of **Vital Chiropractic** with respect to my protected health information.

**Vital Chiropractic** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority