



CHIROPRACTIC

TERMS OF ACCEPTANCE

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)



NEW MEMBER INFORMATION

Welcome to our office! Please complete all questions.

Name:		Date:	
Address:		City/State/Zip:	
Home Phone:		Work Phone:	
Birth Date:		Age:	Social Security #:
Marital Status:		M	W
		D	S
		Spouse's Name:	
Your Employer:		Occupation:	
Children's Names and Ages:			
E-mail address:			
Method of Payment for First Visit: Cash Check Credit Card Insurance			

Reasons For Consulting Vital Chiropractic Center:

1. _____
2. _____
3. _____
4. _____

Who may we thank for referring you? _____

The human body is designed to be healthy. Throughout life, events occur which can limit your life and health expression. Your Nervous system, comprised of the Brain and Spinal Cord is the master control system of the body responsible for regulating and directing every single organ, gland, and tissue in the body 24 hours per day 365 days per year. Since birth we have been encountering stress in our every-day life that can cause interference to this vital system. This case history will uncover possible sources for Nervous System Interference which could limit your life and health expression.

Your Nervous System is susceptible to interference from the first day it is formed. After conception, the Nervous System is the first structure formed in the fetus. It's responsibility is to coordinate and direct the formation on an entire human being. Your growth in the womb and your birth experience are critical to the rest of your development, because they are events in which can be traumatic to the Nervous System decreasing ones life and health potential at the start of their life.

Please circle the best response

- | | | | |
|-----|----|--------|--|
| Yes | No | Unsure | 1. Pregnancy – Did your mother? |
| Yes | No | Unsure | smoke or drink alcohol? |
| Yes | No | Unsure | have a proper diet? |
| Yes | No | Unsure | exercise through her pregnancy? |
| Yes | No | Unsure | experience any falls and injuries during pregnancy? |
| Yes | No | Unsure | experience any physical and/or mental abuse? |
| Yes | No | Unsure | have any illnesses during pregnancy? |
| Yes | No | Unsure | take any prescription medication/OTC medication during pregnancy? |
| Yes | No | Unsure | have regular Nervous System/Chiropractic Check ups during pregnancy? |

2. **Birth History**

- | | | | |
|-----|----|--------|---|
| Yes | No | Unsure | Was the delivery long? Length: _____ |
| Yes | No | Unsure | Was the delivery difficult? List Difficulties: _____ |
| Yes | No | Unsure | _____ |
| Yes | No | Unsure | Forceps or extraction devices used? |
| Yes | No | Unsure | Caesarean? |
| Yes | No | Unsure | Breach or Cephalic? |
| Yes | No | Unsure | Home Birth? |
| Yes | No | Unsure | Hospital Birth? |
| Yes | No | Unsure | Mother given drugs during delivery? _____ |
| Yes | No | Unsure | Was labor induced? |
| Yes | No | Unsure | Were you checked by a Chiropractor for Nervous System Interference? |
| Yes | No | Unsure | Post labor difficulties? If yes, please explain: _____ |
| | | | _____ |

3. **Growth & Development**

- | | | | |
|-----|----|--------|--|
| Yes | No | Unsure | Did you have regular spinal check-ups for Nervous System Interference? |
| Yes | No | Unsure | Were you breast fed? How Long? _____ |
| Yes | No | Unsure | Childhood sicknesses? _____ |
| Yes | No | Unsure | Accidents? _____ |
| Yes | No | Unsure | Surgery? _____ |
| Yes | No | Unsure | Drugs/Medications? _____ |
| Yes | No | Unsure | Did you fall while learning to walk? |
| Yes | No | Unsure | Did you rough house with siblings or friends? |
| Yes | No | Unsure | Child Abuse? |
| Yes | No | Unsure | Spanking / Pulling on ear, chin, arms or legs etc.. |
| Yes | No | Unsure | Other traumas? _____ |

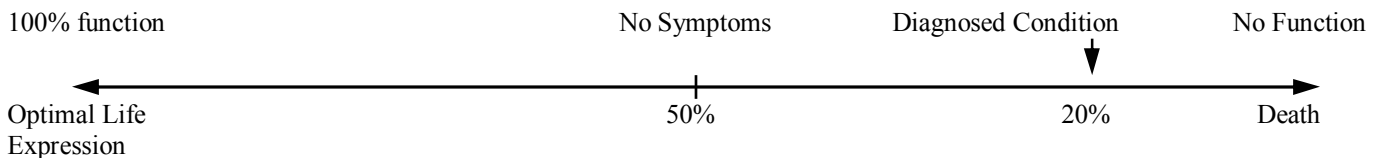
As we continue life we still encounter stress that can impact our Nervous System and cause interference. Lifestyle choices affect your level of Nervous System Interference. Nervous System Interference is caused

Current Issues

Yes	No	Unsure	Did/Do you smoke? How Much / How Long? _____
Yes	No	Unsure	Did/Do you drink alcohol? How Much? _____
Yes	No	Unsure	Do you eat healthy foods? _____
Yes	No	Unsure	Have you been in accidents? Explain: _____
<hr/>			
Yes	No	Unsure	Have you had surgery? Organs removed / replaced? _____
Yes	No	Unsure	Drugs? Prescription / Non-prescription? _____
Yes	No	Unsure	Exercise regularly? Activity _____ Days per week _____
Yes	No	Unsure	Do you sleep soundly? Hours per night? _____
Yes	No	Unsure	Did/Do you have occupational stress? _____
Yes	No	Unsure	Physical Stress? _____
Yes	No	Unsure	Mental Stress? _____
Yes	No	Unsure	Any other traumas or problems? _____
Side	Back	Stomach	Sleeping Posture _____

When an individual begins life with limited health and life expression as a result of Nervous System Interference, and continue to encounter thoughts, traumas, and toxins. After the body's function has been decreased for long periods of time the body is unable to run at it's best and is unable to carry out it's responsibility of running all body functions. Eventually the body has to tell us about the injustice we are doing to it and talks to us through symptoms. The symptoms are collectively named by doctors as a disease.

Wellness Scale



Please mark the wellness scale above with a circle where you feel you are currently and a star with where you want to be in the future.

How does your current complaint affect your daily activities? _____

Does it affect your family? _____

How has having this complaint changed your life? _____

How does having this complaint make you feel? _____

Do you have any other concerns? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

X-Ray Consent Form

The doctor has explained the purpose of the x-rays to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates of Vital Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature: _____ Date: _____

Parental Consent Form

I _____ give the doctors of Vital Chiropractic, Mount
(Print Parent's Name)

Vernon, WA permission to provide chiropractic care, including any necessary exams and

adjustments, to my child, _____
(Print Childs Name)

Signed: _____ Date: _____
(Parent Signature)

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