VITALITY CHIROPRACTIC & REHAB
SPORTS | PREGNANCY | WELLNESS

PATIENT INFORMATION

Date _____/_____/_____

First Name _____ Middle Name _____
Last Name _____

Street Address _____
Address Line 2 _____

City _____ State _____ Zip _____

Mobile Phone ____-____-_____ Work Phone ____-____-_____ Home Phone ____-____-_____

Email Address_____

Date of Birth ____ / ____ / _____ Gender Male Female
Height _____'_____" Weight _____ lbs.
Occupation_____

Marital Status: Single☐ Married ☐Separated ☐Divorced ☐Widowed☐ Other_____

Pregnant: YES ☐ NO ☐ Trying ☐ N/A ☐
Yes: Trimester _____
Trying: How long _____

Number of Children _____ Spouse's Name _____

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EMERGENCY CONTACT / HIPAA RELEASE INFORMATION

Patient's Name _____
Patient's Date of Birth:_____
Patient's address:_____

Name of patient's Personal Representative:_____
Personal Representative's phone: _____
Personal Representative's address: _____
Personal Representative's Relation to Patient: _____

Any limitations on issues your personal representative may discuss? Yes ☐ NO ☐
If yes, please specify:_____
Expiration date for this designation (unless / until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at Vitality Chiropractic & Rehab.

REQUIRED SIGNATURES:

_____ _____
Personal Representative signature Date

_____ _____ _____
Patient Signature Date

EMERGENCY CONACT:
Name:_____
Phone:_____
Relationship:_____

Can information pertinent to the patient be released to this person Yes ☐ NO ☐

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HOW DID YOU HEAR ABOUT US?

Word of Mouth ☐ Advertisement ☐ Social Media ☐ Direct Marketing ☐ Internet

Personal Referral from _____

REFERRAL INFORMATION

Referring Physician _____ Contact Info _____

SPECIFIC TREATMENT CASE

Are You Working with an Attorney? Yes ☐ No ☐
Yes; Attorney Name _____
Company _____

Is this a Work Compensation case? Yes ☐ No ☐
Yes;
Company Name _____
Company Address _____
Incident Date ____ / _____ /_____
Insurance Company _____

Is this an Auto Case? Yes ☐ No ☐
Yes;
Auto Insurance Phone Number ____-_____-_____
Name of Adjuster _____-
Policy Number _____
Claim Number _____

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REASON FOR VISIT

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

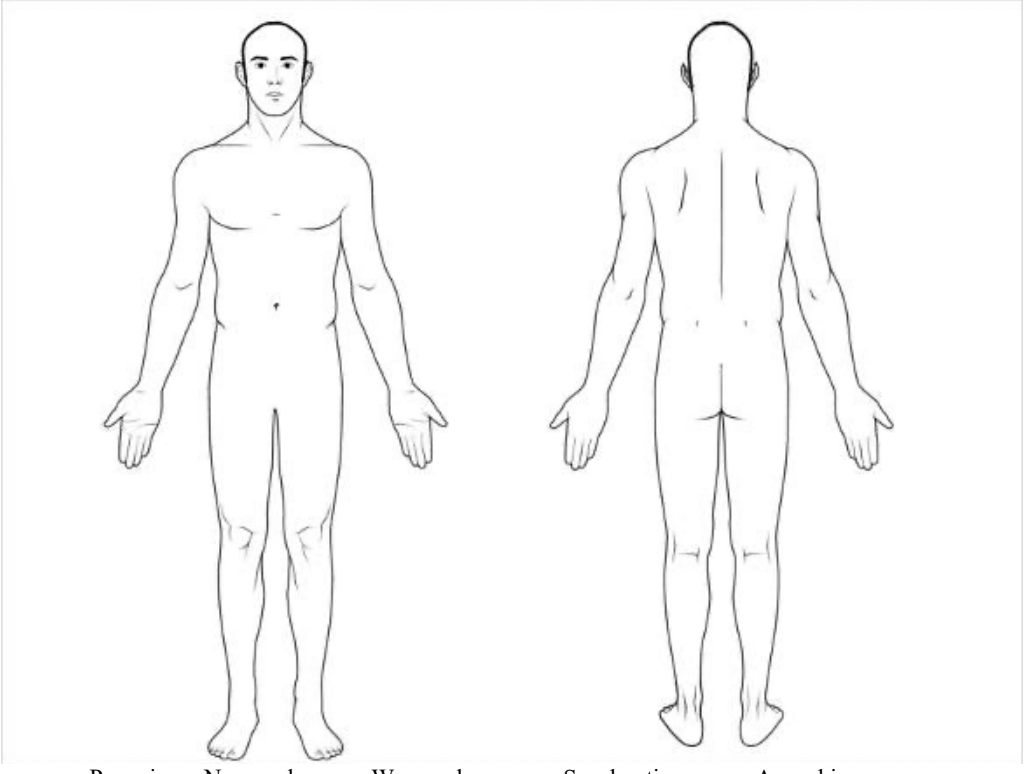
What caused this condition? _____

_____

What is the date this condition began? _____/_____/ _____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

On the body diagrams below, please indicate your areas of symptoms by drawing in the appropriate symbols. P – pain N – numbness W – weakness S – shooting A – aching



P – pain N – numbness W – weakness S – shooting A – aching

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On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None 0 1 2 3 4 5 6 7 8 9 Unbearable 10

How often do you feel the discomfort?

Constant ☐
Frequent ☐
Occasional ☐
Intermittent ☐

How has this complaint changed since the onset?

Worsened ☐
Remained the same ☐
Improved ☐

What aggravates this condition? _____

What improves this condition or gives you relief? _____

What treatment have you received for this condition up to now? _____

Have other health care provider(s) performed tests related to this condition? _____

Have you ever had any previous episodes of this condition? _____

Medical History/ Current Health

Check (X) if you have had any problems with any of the following:

	AIDS		Cortisone Treatments		High Blood Pressure		Scarlet Fever
	Anemia		Persistent Cough		HIV Positive		Shortness of Breath
	Arthritis, Rheumatism		Cough Up Blood		Jaw Pain		Skin Rash
	Artificial Heart Valve		Diabetes Type:		Kidney Disease		Stroke
	Artificial Joints		Epilepsy		Liver Disease		Swelling of Feet/ Ankles
	Asthma		Fainting		Mitral Valve Problems		Thyroid Problems
	Back Problems		Glaucoma		Nervous Problems		Tobacco Habit
	Blood Disease		Headaches		Pacemaker		Tonsilitis
	Cancer		Heart Murmur		Psychiatric Care		Tuberculosis
	Chemical Dependency		Heart Problems		Radiation Treatment		Ulcer(s)
	Chemotherapy		Hemophilia		Respiratory Disease		Venereal Disease
	Circulatory Problems		Hepatitis		Rheumatic Fever		Other

Explanation:

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Family History & Personal History

Are you presently taking any medication? Yes ☐ Explain _____ No ☐

Have you had any surgical procedures? Yes ☐ Explain _____ No ☐

Are there any past illnesses or conditions we should be aware of? Yes ☐ Explain _____ No ☐

Do you have a past history of accidents or trauma? Yes ☐ Explain _____ No ☐

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? Yes ☐ Explain _____ No ☐

Do you have any known allergies? If so please list: Yes ☐ Explain _____ No ☐

Social Habits & Work

Current work habits: select all that Apply

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired
- ☐ Unemployed
- ☐ Student; School _____

Social habits: select all that Apply

- ☐ Smoke or use tobacco products_____
- ☐ Drink alcohol
- ☐ Use recreational drugs _____

Present exercise habits: select all that Apply

- ☐ Exercise Daily
- ☐ Minimal Exercise
- ☐ No exercise prior to pain
- ☐ Cannot exercise due to current pain

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Privacy & Informed Consent for Treatment

I certify that the above medical information is correct to my knowledge. I will not hold Dr. Caitlin Jordan DC, MS or any member of her/ his staff responsible for any errors or omission that I may have made in the completion of this form.
I authorize the clinic of Vitality Chiropractic & Rehab and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic of Vitality Chiropractic & Rehab and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

PATIENT ACKNOWLEDGMENT

I, _____, hereby acknowledge that I contacted Dr. Caitlin Jordan DC, MS and Vitality Chiropractic & Rehab associates in regards to treatment. Dr. Jordan and the Associates of the clinic did not contact me in any way and my treatment has solely been a result of my contacting her and or associates. By signing below you agree to the patient acknowledgment.

_____ _____/_____/_____
PRINT PATIENT NAME DATE SIGNED

_____
PATIENT SIGNATURE

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated.

_____ _____/_____/_____
PRINT PATIENT NAME DATE SIGNED

_____
SIGNATURE OF REPRESENTATIVE

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***Patient Rights*:** You have the right to be informed and educated on your condition, the recommended chiropractic treatment, and potential risks involved with the recommended treatment. You also have the right to refuse treatment after being informed on your condition.

I request consent to chiropractic adjusts and other chiropractic procedures, including various modalities of physical therapy and diagnostic imaging such as radiographs. The chiropractic treatment may be performed by Dr. Caitlin Jordan DC, MS and or other licensed doctors working in the clinic of Vitality Chiropractic & Rehab.

I have had the opportunity to discuss with Dr. Caitlin Jordan, my diagnosis, nature and purpose of the chiropractic treatment, risks, and benefits of the chiropractic treatment, alternatives to the treatment such as physical therapy, acupuncture, or other medical intervention, and or no treatment at all.

I understand that, there are some risks to chiropractic treatment which include however, not limited to the following:

Broken bones
Dislocations
Strains/ Sprains
Burns / Frostbite (Physical therapy modalities)
Worsening / aggravation; spinal conditions
Bruising / Swelling
Other _____

Increased symptoms and or pain
No improvements of pain and or symptoms
Infections (Acupuncture, Massage)
Punctured lung (Acupuncture, Broken rib)
New symptoms and or pain

In rare cases there have been reports of complications of vertebral artery dissection also known as stroke when a patient receives a cervical (neck) adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, and other loss of voluntary muscles as well as death.

I do not expect the doctor to be able to anticipate and or explain all these risks or complications. I also understand there that there is no guarantee or promises made to me about my condition and or results of treatment.
I have read, or have it read to me the above statements. I have had the opportunity to ask any questions and answered to my satisfaction.
By signing below, I consent to the treatment and treatment plan. I intend this consent to cover the entire course of treatment for my current condition under Vitality Chiropractic & Rehab doctors and it's healthcare professionals.

_____ _____/_____/_____
PRINT PATIENT NAME DATE SIGNED

_____
PATIENT SIGNATURE

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated.

_____ _____/_____/_____
PRINT PATIENT NAME DATE SIGNED

_____
SIGNATURE OF REPRESENTATIVE

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PAYMENT POLICY

Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.

Payment options: Cash, Check, Major Credit Cards, Health Savings Accounts
Checks: We charge $35.00 for returned checks

Insurance:

For patients with chiropractic coverage, we are happy to work with your carrier to maximize your benefits and submit all necessary documentation in order for you to received reimbursements for your treatment.

Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.

In-Network Policies: We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement.

Co-pays will be paid by patient, reimbursement checks will be payable to us.

If your policy has a deductible feature, it is due at the time of service. We will do our very best to answer any questions you may have in regard to your insurance.

Insurance

Primary_____
Person responsible for the account _____
Relationship to the patient _____ Birthdate _____/_____/_____
Name of Employer _____ Work Phone _____-_____-_____
Business Address _____ City _____ State ____ Zip _____
Insurance Company _____ Group # _____
Member ID _____

Secondary Insurance _____
Subscriber Name _____
Relationship to the patient _____ Birthdate _____/_____/_____
Name of Employer _____ Work Phone _____-_____-_____
Business Address _____ City _____ State ____ Zip _____
Insurance Company _____ Group # _____
Member ID _____

By my signature below, I acknowledge that I have read and agree to the above statements.

_____ _____/_____/_____
PRINT PATIENT NAME DATE SIGNED

_____
PATIENT SIGNATURE

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated.

_____ _____/_____/_____
PRINT PATIENT NAME DATE SIGNED

_____
SIGNATURE OF REPRESENTATIVE