PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Birthday: _____ Sex: ☐ Male ☐ Female
Cell Phone: _____ Email: _____
Social Security #: _____ Driver's License #: _____
Check One: ☐ Married ☐ Single ☐Widowed ☐ Divorced ☐ Separated
Preferred Language: ☐ English ☐ Spanish ☐ Other _____
Ethnicity (Check all that apply): ☐ Caucasian ☐ African/African American ☐ Asian/Asian American
☐ Hispanic/Latino ☐ Hawaiian/Pacific Islander ☐ Other: _____

Business Employer: _____ Type of Work: _____
Business Phone: _____
Name of Spouse: _____ Spouse's Social Security #: _____
Spouse's Employer: _____ Type of Work: _____
Business Phone: _____
Names and Ages of Children: _____

Referred to Office By: _____
Emergency Contact: _____ Emergency Contact #: _____
Relationship to Emergency Contact: _____

Who is Responsible for Your Bill? You and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medical
Insurance Company: _____ Member ID: _____ Group Number: _____

PAST HEALTH HISTORY

Major Surgeries/Operations (Describe and Date):

_____

_____

Major Accidents or Falls (Describe and Date):

_____

_____

Hospitalization (Other Than Above):

_____

_____

Allergies:

_____

_____

Ongoing Medical Conditions:

_____

_____

Family Medical History:

_____

_____

What Were You Doing For Preventive Care:

_____

_____

Please List Past Medications, Vitamins, and Dose:

_____

_____

In the Past Have You : ☐ Smoked ☐ Consumed Alcohol ☐ Consumed Coffee ☐ Consumed White Sugar

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

Other Doctors Seen for This Condition? ☐ Yes ☐ No If yes, who? _____

Is Condition Related to: ☐ Job ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other _____

When Did This Condition Begin? _____ Has This Occurred Before? ☐ Yes ☐ No

Date of Accident: _____ Time of Accident: _____

Have You Made a Report to Your Employer? ☐ Yes ☐ No

Do You Wear a Shoe Lift? ☐ Yes ☐ No

Do You Currently : ☐ Smoke ☐ Consume Alcohol ☐ Consume Coffee ☐ Consume White Sugar

Please List Current Medications, Vitamins, and Dose:

_____

_____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

_____

_____

Most patients that come to our office have one of two objectives in concerning their health care. Some patients come from symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Dr. Elizabeth Weidlich will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Doctor's Selection Based on Condition

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Vitality Chiropractic Wellness Inc will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Vitality Chiropractic Wellness Inc will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Print Name: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

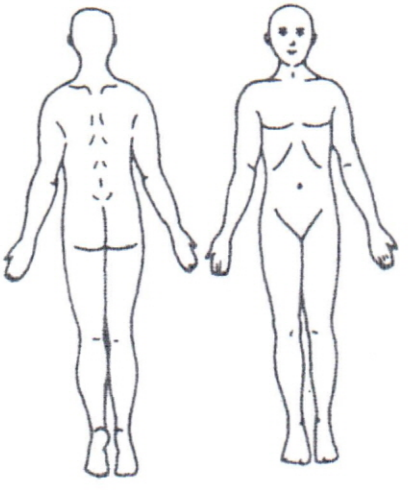
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

Informed Consent to Screenings and Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).
I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.
I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.
I hereby consent to the above mentioned screening(s). I understand that the data derived from the screening(s) are not diagnostic. Initiating a follow-up examination with my primary care provider to confirm screening results is my responsibility. I hereby release Dr. Elizabeth Weidlich and *Vitality Chiropractic Wellness Inc.* from all liability arising from or in any way connected with these screenings or derived data.

Acknowledgement of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of *Vitality Chiropractic's* "Notice of Privacy Practices". As required by the Privacy Regulations, the staff from *Vitality Chiropractic* has explained the "Notice of Privacy Practices" to my satisfaction.
As required by the Privacy Regulations, I am aware that *Vitality Chiropractic* has included a provision that reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that maintains. I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."
Requests:

☐ I wish to file a "Request for Restriction" of my protected health information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices":

_____

I have received the policy statement and have read and agree to the policies therein.

Sign Name: _____ Date:_____

Print Name: _____

Signed form received by: _____ Date:_____

Massage Client Intake Form:

Have you ever had a professional massage? Y N If yes, how often? _____
Are you pregnant? Y N If yes, how far along? _____
Are you sensitive to touch/pressure? Y N If yes, in what area? _____
Are you allergic to any oils? (essential oils, nut oils, scents)? Y N If yes, please list:

_____

Massage Client Waiver Form:

Please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

_____

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____

I affirm that I have notified my therapist of all known medical conditions and injuries.

_____

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

_____

I understand that the massage is entirely therapeutic and non-sexual in nature.

_____

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

_____

I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment. This fee is monetary and can't be taken as an additional "punch" off a massage package card. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.

_____

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible. Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

I have received the policy statement and have read and agree to the policies therein.

Sign Name: _____ Date: _____

Print Name: _____

Signed form received by: _____ Date: _____