Vitality Sports Chiropractic
139 Norcross St. Roswell GA. 30075
678-321-1710/Fax: 678-321-1711

Chiropractic Case History

Name_____ Sex M F Date_____

What you preferred to be called_____

Address_____ City_____ State_____ Zip_____

H. Phone(_____)_____W. Phone_____ Cell Phone_____

Date of Birth_____Age_____

Referred by_____

Occupation_____ Employer_____

E-Mail_____

Status: Minor Single Married Divorced Widowed

Do you have children? Yes No How many?_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking care:

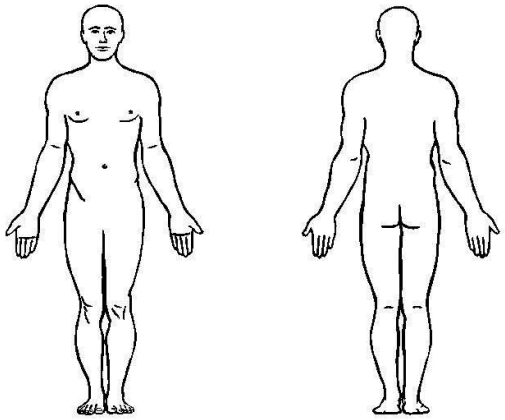
Primary reason: _____

Secondary reason: _____

Describe your symptoms: _____

_____

2. Location of Complaints (Indicate where you have your symptoms)



Complaint Began when and how? _____

_____

Please circle the quality of the complaint/pain: Dull Aching Sharp Shooting Burning Throbbing Tingling Numb

How are your symptoms changing? Getting Better_____
Not Changing _____ Getting Worse _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body?
Where? _____

Grade Intensity/Severity (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How much does it interfere with work? _____ With Social Activities? _____

How frequent is complaint present? Constant (76-100%)_____ Frequent (51-75%)_____ Occasionally (26-50%)_____

Intermittently (0-25%)_____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Who else have you seen for your symptoms.? Previous interventions, treatments, medications, surgery:

_____

_____

4. What Tests have you had for your symptoms? X-Rays Date:_____ MRI Date:_____ CT Scan Date_____

5. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which?

_____

C. Allergies _____

D. Medications: Including Muscle relaxers, Pain killers, Nerve pills

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

6. Family Health History:

Associated health problems of relatives: _____

_____

7. Social and Occupational History:

A. Do you take Vitamins/Supplements? Please list: _____

_____

_____

B. Do you smoke? How many packs? ____ **How Long?** _____ **Do you drink alcohol? How many a week?** _____

C. How many fruits and vegetables do you eat daily? Fruits _____ **Veggies** _____

D. How many glasses of water do you drink daily? _____

E. Are you wearing: Shoe lifts_____ **Inner Soles** _____ **Arch Supports** _____

F. What is your exercise routine? _____

_____

G. Job description: _____

H. Work schedule: _____

I. Recreational activities: _____

PLEASE INITIAL

_____ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

_____ Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business.

_____ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or other medical/legal services engaged on my behalf.

_____ I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

Parent or Guardian: I authorize the staff to administer treatment as deemed necessary for my (Relationship) _____

Signature_____ Date_____/_____/_____

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Roswell, GA. 30075
678-321-1710/Fax 678-321-1711
www.vitalitysportschiropractic.com

Health Insurance Info

Carrier Ins Co phone

Address

Policy # Group #

Patient Relationship to the insured Self Spouse Child Other

If you are covered under another persons insurance…. Please complete

Name of Insured

Address of insured

Phone of insured Sex Birth date

Insured's Employer

Address

Employer Phone Plan Name

Auto Accident Insurance Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

In Case of Emergency

Whom should we contact? _____

Relation: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Who is your Medical Doctor? _____

MD's Phone: _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ understand that as part of my healthcare, Vitality Sports Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment. I understand that this information serves as:

-A basis for planning my care and treatment.

-A means of communication among the many health professionals who contribute to my care.

-A source of information for applying my diagnosis and surgical information to my bill.

-A means by which third party payers can verify what services were billed and actually provided.

-A tool for the routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of the information uses and disclosures. I understand that I have the following rights and privileges:

-The right to review the notice prior to signing this consent.

-The right to object to the use of my health information for directory purposes.

-The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Vitality Sports Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should Vitality Sports Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use and disclosure of my health information: _____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and email.

PLEASE CIRCLE

I fully understand and ACCEPT/DECLINE the terms of this consent

Patient Signature _____ Date _____

1. What was the date of the accident?_____

2. What time did the accident occur?_____

3. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occured? _____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe _____

11. Where were you sitting in the vehicle during the accident? _____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -Yes - No

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? – yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totalled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43 _____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxers - neck brace

42. Were x rays taken at the hospital? If yes, which area was taken? _____

43. If a traffic violation was issued, to whom was it issued? _____

45. Please indicate by circling below what your daily job duties are and any activates you may be asked to perform.

Standing Sitting Walking Lifting Driving Twisting Crawling Bending Typing Manual Labor

49. Are there any positions you can work in without pain? _____

Prior to the injury were you able to work on an equal basis as others in your position? _____

50. Have you hired an attorney? Yes_____ Whom? _____ No_____

Phone number to attorney's office _____

I direct my attorney to pay any outstanding bills out of my settlement, or I will be responsible for all treatment expenses incurred by this accident.

Signature _____ Date _____

AUTO ACCIDENT/PERSONAL INJURY FINANCIAL AGREEMENT

IT IS THE POLICY OF THIS OFFICE TO HAVE THE PATIENT OR THE PATIENT'S ATTORNEY PROVIDE US WITH THE NECESSARY INFORMATION.

IN THE EVENT THAT THE AUTO INSURANCE/ATTORNEY DENIES PAYMENT FOR SERVICES RENDERED TO YOU BY THIS CLINIC, THAT UNPAID PORTION WILL BE TRANSFERRED TO YOU.

THE FOLLOWING CRITERIA MUST BE MET IN ORDER FOR A PORTION OF THE DOCTOR'S FEES TO BE DEFERRED UNTIL A SETTLEMENT HAS BEEN REACHED:

1-ALL AUTO ACCIDENT CASES INVOLVING NO FAULT CLAIMS MUST PROVIDE A COPY OF THEIR AUTO INSURNACE CARD AND ALSO HAVE AN "APPLICATION OF BENEFITS" FORM SIGNED.

2-IN ALL CASES, IF AN ATTORNEY IS INVOLVED, A DOCTOR'S LEIN FORM MUST BE SIGNED BY THE PATIENT AND THE REPRESENTING ATTORNEY. THIS ALLOWS THE REMAINGIN DOCTOR'S FEES TO BE PAID FROM THE FINAL STTLEMENT.

3-THE MERITS OF YOUR CASE MUST BE ESTABLISHED BY YOUR ATTORNEY AND COMMUNICATED TO THE DOCTOR(S).

IN CONSIDERATION OF YOUR UNDERTAKING CARE OF ME, I AGREE TO THE FOLLOWING:

IN THE EVENT ANY INSURANCE COMPANY/ATTORNEY OBLIGATED BY CONTRACTUAL AGREEMENT TO MAKE PAYMENT TO ME OR TO THE CLINIC FOR CHARGES MADE FOR YOUR SERVICES, REFUSES TO MAKE SUCH PAYMENT WITHIN 60 DAYS OF YOUR BILLING, I WILL BE RESPONSIBLE FOR THAT AMOUNT. I WILL HAVE 30 DAYS TO CLEAR THAT ACCOUNT BY CALLING THE INSURANCE COMPANY/ATTORNEY AFTER BEING NOTIFIED BY YOUR OFFICE. IN ANY EVENT, IF MY BALANCE IS NOT CLEARED IN FULL WITH YOUR OFFICE AND SERVICES OF AN OUTSIDE COLLECTION AGENCY IS REQUIRED; I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AND ALL ADDITIONAL COLLECTION COSTS IN ADDITION TO MY OUTSTANDING BALANCE. INCLUDING BUT NOT LIMITED YO ATTORNEY'S FEES, COURT COSTS, ETC.

I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

_____

DATE SIGNATURE OF RESPONSIBLE PARTY

WITNESS-DATE_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

ACCIDENT, PRIVATE, AND GROUP HEALTH INSURANCE

I HEREBY DIRECT AND INSTRUCT _____ INSURANCE COMPANY TO PAY BY CHECK AND TO BE MADE PAYABLE TO AND SENT DIRECTLY TO:

VITALITY SPORTS CHIROPRACTIC

139 NORCROSS ST.

ROSWELL, GA. 30075

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE THE CHECK PAYABLE TO ME WITH THE **VITALITY SPORTS CHIROPRACTIC** AS THE SECONDARY PAYE AND MAIL IT TO THE ADDRESS LISTED ABOVE.

THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE AND OTHRWISE PAYABLE TO ME UNDER MY CURRENT POLICY AS PAYMENT TOAWRDS THE TOTAL CHRAGES FOR PROFESSIONAL SERVICES RENDERED. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO THE ABOVE MENTIONED ASSIGNEE. I HAVE AGREED TO PAY, IN CURRENT MANNER, ANY AND ALL BALANCES OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

SHOULD I CHOOSE TO TERMINATE MY CASE WITH MY ATTORNEY OR STOP RECEIVING CARE FROM THE PROVIDERS AT VITALITY SPORTS CHIROPRACTIC, I WILL IMMEDIATELY NOTIFY VITALITY SPORTS CHIROPRACTIC OF SAID TERMINATIONS AND AGREE TO PAY MY BALANC IN FULL WITHIN 30 DAYS, OR PROVIDE NEW ATTORNEY INFORMATION.

A PHOTOCOPY OF THIS ASSIGMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY IVOLVED IN THIS CASE.

DATED AT VITALITY SPORTS CHIROPRACTIC THIS_____DAY OF _____,20_____.

_____ _____

PATIENT SIGNATURE OR RESPONSIBLE PARTY IF MINOR **WITNESS**

Vitality Sports Chiropractic
139 Norcross St.
Roswell, GA. 30075
678-321-1710/FAX 678-321-1711

AUTHORIZATIONS AND RELEASES

NAME_____ CASE#_____

CONSENT FOR TREATMENT

I, THE UNDERSIGNED HEREBY AUTHORIZE DR. WISKIND AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANT/S TO PERFORM DIAGNOSTIC TESTS, INCLUDING BUT NOT LIMITED TO X-RAYS, AND TO ADMINISTER TREATMENT AS NECESSARY. I ALSO CERTIFY THAT NO GUARANTEE OR ASSISTANCE HAS BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED. I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENTAL INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN INSURANCE CARRIER AND MYSELF. FUTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLCTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFICE WILL BE CREDITED TO MY ACCOUNT UOPM RECEIPT. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THE I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature_____ Date_____ Witness_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE DR. _____ TO RELEASE AN YMEDICAL INFORAMTION PERTINENT TO MY TREATMENT PLAN TO VITALITY SPORTS CHIROPRACTIC LLC OR AN AUTHORIZED REPRESENTATIVE FOR REVIEW. THIS AUTHORIZATION FOR RELEASE OF INFORMATION SHALL REMAIN VALID FOR THE TERM OF MY COVERAGE UNDER MY CURRENT POLICY. I CERTIFY THAT ALL INSURANCE INFORMATION GIVEN TO THIS CLINIC IS CORRECT AND COMPLETE. I ALSO KNOW THAT I AM ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION FORM.

Patient's Signature_____ Date_____ Witness_____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I HERBY AUTHORIZE THE _____ INSURANCE COPMANY/ADMINISTRATOR TO PAY BY CHECK, AND FOR IT TO BE MAILED DIRECTLY TO VITALITY SPORTS CHIROPRACTIC 139 NORCROSS ST, ROSWELL, GA. 30075 THE EXPENSE BENEFITS ALLOABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT POLICY, AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I HAVE AGREEED TO PAY, IN CURRENT MANNER, ANY BALANCE OF SAID APPLICABLE CHARGES. I AGREE THAT THIS OFFICE BE GIVEN POWER OF ATTORNEY TO ENDORES/SIGN MY NAME ON ANY AND ALL DRAFTS FOR PAYMENT OF MY BILL.

Patient's Signature_____ Date_____ Witness_____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, THE UNDERSIGNED PATIENT, AM DIRECTING MY ATTORNEY, _____, TO PAY ANY OUTSTANDING BILLS OUT OF MY SETTLEMENT AND, IN EFFECT, PROTECTING ANY SUCH BALANCE. I HEREBY MAKE AND DECLARE THE INSTRUCTIONS HEREIN CONTAINED TO BE IRREVOCABLE. I FULLY UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE FOR ALL MEDICAL BILLS AND THIS AGREEMENT IS MADE SOLELY FOR THE DOCTOR'S ADDITONAL PROTECTION AND CONSIDERATION OF HIS AWAITING PAYMENT. I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON AN YSETTLEMENT, JUDGEMENT OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE. I HAVE BEEN ADVISED THAT IF MY ATTORNEY DOES NOT WISH TO COOPERATE IN PROTECTING THE DOCTOR'S INTERESTS, THE DOCTOR WILL NOT AWAIT PAYMENT, BUT WILL REQUIRE ME TO MAKE PAYMENT ON A CURRENT STATUS.

Patient's Signature_____ Date_____ Witness_____

CONSENT FOR THE TREATMENT OF A MINOR

I HEREBY AUTHORIZE DR WISKIND AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANT TO PERFORM DIAGNOSTIC TESTS, INCLUDING BUT NOT LIMITED TO X-RAYS, AND TO ADMINSITER TREATMENT AS HE DEEMS NECESSARY TO MY (**RELATIONSHIP OF CHILD**) _____
(**CHILD'S NAME**)_____.

GUARDIAN'S SIGNATURE _____ DATE_____ WITNESS _____

X-RAY/MEDICAL RELEASE

I HAVE REQUESTED THE RELEASE OF RECORDS OF _____ WHICH ARE A PART OF THE RECORD AT _____.

I HEREBY REQUEST AND AUTHORIZ YOU, YOUR EMPLYEES AND AGENTS TO FURNISH TO THE PERSON(S) LISTED BELOW OR ANYONE DESIGNATED IN WRITING BY THEM, ALL COPIES OF RECORDS AND REPORTS, INCLUDING COPIES OF X-RAYS AND PHOTOSTATIC COPIES, ABSTRACTS, OR EXCERPTS OF ALL RECORDS AND ANY OTHER INFORMATION THEY MAY REQUEST RELATING TO ANY EXAMINATION, TREATMENT OR OPINION CONCERNING ANY CONDITION THAT I MAY HAVE HAD I NTHE PAST, NOW HAVE, OR MAY HAVE IN THE FUTURE.

PLEASE FORARD THIS TO (NAME)_____ (ADDRESS)_____

Patient's Signature_____ Date_____ Witness_____