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

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:

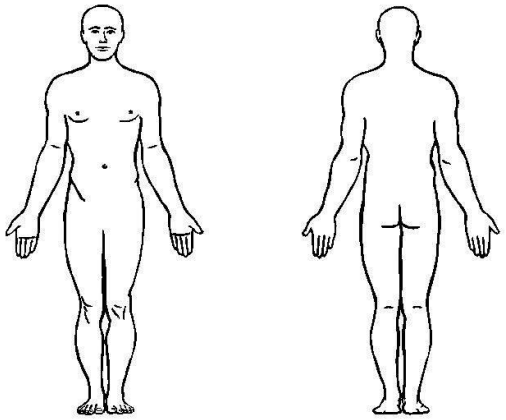
Primary reason: _____

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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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 _____