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New Patient History and Health Concerns

**Please do your best to fill out everything on this intake form. It is important that I understand past and current stressors that may have affected or could affect your health.*

Check type of care desire: ___Temporary Relief___Stabilization ___Family Health/Prevention

Name: _____ Date: _____

Address:_____ City:_____ State:_____

Phone: (Home)_____ Cell:_____

Email Address:_____ Date of Birth:_____

Height:_____ Weight:_____ Age:_____ Gender Pronoun:_____

Active Military/Veteran: ____Yes _____No Pregnant? _____Yes_____ No

Number of Children:_____ Names & Ages_____

_____

Single/Married/Widowed/Life Partnered- Name:_____

Emergency Contact:_____Relationship:_____Phone:_____

Who referred you to our office:_____ May we thank them: ___yes ___ no

PLEASE LIST 3 TOP HEALTH CONCERN

List Main concern 1st	**Rate the severity 0=no pain 10= Hospital**	**When did this start?**	**Have you had this in the past ?**	**Did the problem begin with this injury?**	**Constant? Or does it come and go (intermittent)**

Since these complaints/concerns started have you seen anyone else for them?_____

If so, Who and when?_____

Have your complaints gotten _____ WORSE _____THE SAME _____BETTER

What makes it better?_____

What makes it worse?_____

Is this condition worse during the day during certain times of the day? ___Y __N

If yes, when?_____

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Does it affect your ___work ____relationship or intimacy ___decision making __exercise or play __ attitude,

mood, patience ___ability to relax or sleep __day to day activities __none

What activities would you like to perform again?_____

If any operations please list and date:_____

_____

List all medications you are currently taking_____

_____

Have you fractured any bones, if yes please list _____

Have you ever been knocked unconscious? _____

Any other bodily traumas that are significant to discuss at this time

_____

Health History *Mark any system or issue you have with* ***(N) for Now or (P) for Past*** *(Including Birth until Now)*

___ Nervous System	___Prostate	___ Arthritis	__Accidents/Falls/Injuries/Concussions
___ Musculoskeletal	___ Eyes	___ Sinuses/Allergies	___ Surgeries/Organ Removal
___ Digestive	___ Ears/Nose/Throat	___ Seizures	___Fractures/Dislocations
___ Respiratory	___ Dental/Jaw issues	___Cancer	___ Cholesterol/Blood Pressure
___ Cardiovascular	___ Thyroid	___Stroke	___ Vaccine/Medication Reactions
___ Immune	___ Adrenals	___ Scoliosis	___ Depression/Anxiety
___ Reproductive	___ Learning Difficulties	___ Anemia	___ Diabetes (Type:_____)
___ Bowels/Bladder	___ Headaches/Migraines	___ Dizziness/Vertigo	___ Family History
___ Numbness/Tingling	___ Autism Spectrum Disorder	___Other_____	

Chiropractic Testing History

Have you ever had **Chiropractic Care**? Y N Doctor or Office's Name:_____

Last visit: _____ Duration of care: _____

Reason for visit: _____ Result: _____

Occupation: _____ How long have you been at this job?_____

Do you enjoy what you do? Yes No Is your job physically and/or mentally stressful? Yes No

Explain:_____

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Life Health

What do you do for **exercise** (type, frequency, duration)? _____

What do you wish you were doing in the way of activity/exercise that you are currently not participating in?

_____

Are you under care of a **psychologist and/or therapist**? Yes No

Name: _____How long? _____

Do you have a history of physical, emotional, verbal, sexual **abuse**, or rape? Yes No

Have you or are you currently addressing that topic with a professional? Yes No

If yes, who: _____ If no, would you like a referral? Yes No

Is there some aspect of your life that very much **pleases** you, brings you joy, or helps you to feel better about yourself? _____

_____

What is your highest health goal?

_____

_____

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Stress Survey: Please circle a number and the examples that apply to you. <u>If not listed, please write in</u>.

0 - no awareness of any stress **1**- slightly stressful **2**- moderately stressful **3**- extremely stressful

Overall Physical Stress/Trauma:

0 1 2 3

Includes: falls, accident, injuries, repeated postural stress, impacts, difficult birth, physical/sexual abuse, etc.

Other:_____

Overall Emotional/ Mental Stress:

0 1 2 3

Includes: loss/separation of loved ones, life changes, abuse, legal concerns, financial concerns, relocation, illness of yourself or loved one, job stress, etc.

Other:_____

Overall Chemical Stress:

0 1 2 3

Includes: drugs, medicines, alcohol, nicotine, caffeine, smoke, fumes, chemical agents, pollution, food additives, poor diet (fast food, fried food), pesticides, non-organic food/body products, etc.

Other: _____

Is there anything else which may help us to understand you, your history, or your needs which have not been discussed on this survey?

Please explain:_____

Participant Signature: _____ Date: _____

**** Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in that process!***

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Vessel Chiropractic Scoring Sheet

Circle the number that resonates with you the most, this scoring sheet is to see how your symptoms impend your daily activities.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travelling (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

_____
Patient's Signature

_____
Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

Vessel Chiropractic: Mission Statement Facilitate in Growth and Evolution of Humanity through the Art , Science and Philosophy of Chiropractic

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HEALTHCARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Healthcare Information (PHI). The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Vessel Chiropractic to use and/or disclose PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS:

I give permission to Vessel Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, other practice related correspondence, information about treatment alternatives or other health related information.

If Vessel Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give permission to Vessel Chiropractic to use my name on a welcome board, referral board, and birthday board.

I give permission to Vessel Chiropractic to use my photograph on their marketing materials such as their flyers, website and ads in print media.

I give permission to Vessel Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

I give Vessel Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Vessel Chiropractic permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Vessel Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

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You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Vessel Chiropractic. The written notice must contain the following information: Your name and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and Your signature.

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by Vessel Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Vessel Chiropractic will not refuse to provide treatment however, it will not be possible for Vessel Chiropractic to contact me to schedule appointments or discuss my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the PHI to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practice for Protected Health Information. My signature below represents agreement with these practices.

Participant's Signature:_____

Parent or Personal Representative (please print): _____

Parent or Personal Representative's Signature:_____

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider. Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name Initials Date

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child Date of Last menstrual cycle:_____

Print Name Initials Date

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No Call, No Show Cancellation Policy.

Here at Vessel Chiropractic, we understand that life can throw us unexpected emergencies. These unanticipated things are not always within our control. Due to appointments being in high demand, we ask that you do your best to notify us in advance about any changes to your appointment. It is our commitment to you as a Vessel participant that you have an exceptional experience here at our office. Out of respect for our chiropractors and other Vessel participants, we appreciate at least 24 hours advanced notice from our practice members when they are unable to keep their scheduled appointment. This is valuable time that can be dedicated to someone who may have an immediate need for care.

I understand:

If I have not shown up within 15 minutes past my scheduled appointment and have not notified the office, it will be considered a No Call, No Show Cancellation. In this case, I will be charged 50% of my appointment cost.

My care plan payments do not cover payment for missed appointments; therefore, I am responsible for these additional charges when applicable.

Optional reminder texts, emails, and/or calls can be made 24 hours prior to my appointment, as a courtesy, and that I am expected to be in attendance of my appointment.

I authorize Vessel Chiropractic to use the credit card I have on file for these additional charges when applicable. To reschedule your appointment, please call (386) 287-1916. If you are unable to reach us, please leave a detailed message on our voicemail system available 24 hours a day, 7 days a week. You may also cancel via email: vesselchiropractic@gmail.com. Thank you for your understanding. We are available to answer any questions you may have. We look forward to caring for you here at Vessel Chiropractic!

Try to make all **recommended adjustments.** Missed adjustments will slow down improvement and extend the time it takes to achieve your health goals. If you miss a visit try to reschedule it for later in the same day or next day. If this happens repeatedly let the chiropractor know so your adjustment schedule can be modified.

I have read and agree to the terms of Vessel Chiropractic No Call, No Show Cancellation policy. Practice

Practice Member Initials: _____ Date: _____

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Financial Policy

Our office strives to provide supportive communication in regards to all aspects of your care from the clinical procedures to the manner in which you pay for services. We hope this financial policy clearly explains management of fees due. Any questions that you have, however, are welcomed and should be directed to the front desk. We want to keep your financial arrangements as simple as possible. In order to do this in a cost effective manner, we ask that you adhere to the following guidelines: (Please initial each line and sign the bottom)

Payment is due at the time of service or before. Acceptable methods of payment are Cash, Check, Visa, MasterCard, American Express, and Discover.

Our policy is to maintain a credit or debit card on file in our secure system. This allows us to settle your account for you quickly and easily and insures that if you find yourself without your usual form of payment, you can still be seen that day. By initialing here you give us permission to run the card you have chosen to keep on file automatically if services have been rendered but not paid for.

3rd Party Billing: Your health insurance policy is a contract between the insurance carrier and yourself. Vessel Chiropractic does not take assignments of benefits from any 3rd party; all fees are your responsibility. As a service to our participants, we will provide the necessary information forms for submission of reimbursement upon request. To keep your costs down, we also offer various in-house discount payment options. Those plans appropriate to you and your family will be covered at your Report of Findings (2nd visit) when you begin care here and at each progress exam, but if you ever have questions about them at a different time, please see the front desk; they'll be happy to review all the information with you.

A 24 hour notice is required if you are unable to keep your appointment to avoid a $25.00 missed appointment fee for Chiropractic Adjustments. All other appointments are full price without 24 hour notice.

Discount plan payments If you choose the discount plan, all payments are due a time of first visit. By singing below you give us permission to run the card you have chosen for all 11 visits up front and receive one visit and progress exam free.

For any check returned by your bank a $35.00 fee will be charged in addition to the check amount.

I have read and agree to the above financial policies terms in the office of Vessel Chiropractic.

_____ _____

Print Participant Name Responsible Party Signature

_____

Date

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