VITAL PERFORMANCE CHIROPRACTIC

# New Practice Member

Name_____ Date of Birth____/____/____ Age_____ Male / Female

Address_____City_____State_____Zip_____

Cell Phone_____Home Phone_____Cellular Provider_____

Email Address_____Occupation_____

Employer's Name_____ Single / Married / Divorced / Widowed

Spouse's Name_____ Who may we thank for referring you? _____

Children: Names, Ages, & Gender_____

## List the health concerns that brought you into this office.

| Health Concern: List according to severity. | Rate of Severity 0 = no pain 10 = unbearable | When did this problem start? | Have you had the problem before? If so, when? | Did the problem begin with an injury? | Are symptoms constant (C) or intermittent (I)? |
|---|---|---|---|---|---|
| A: | | | | | |
| B: | | | | | |
| C: | | | | | |
| D: | | | | | |

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____When?_____Results?_____

## Please mark "P" if in the past OR Mark "C" if currently struggle with:

| | | | | |
|---|---|---|---|---|
| ____Headaches | ____Ear Infections | ____Sinus Issues | ____Kidney Problems | ____Sexual Dysfunction |
| ____Migraines | ____Hearing Loss | ____Frequent Colds | ____Bladder Problems | ____Sleep Problems |
| ____Jaw/TMJ Pain | ____Ringing in the Ears | ____Thyroid Issues | ____Menstrual Problems | ____Tight/Sore Muscles |
| ____Neck Pain | ____Dizziness | ____Asthma | ____Prostate Problems | ____Sports Injury |
| ____Shoulder Pain | ____Loss of Energy | ____Chest Pain | ____Infertility | ____Sciatica |
| ____Arm Pain | ____Nervousness | ____Heart Problems | ____Fibromyalgia | ____Arthritis/Joint Pain |
| ___ Upper Back Pain | ____Double/Blurry Vision | ____Nausea | ____Epilepsy/Convulsions | ____GERD/Gastric Reflux |
| ____Mid Back Pain | ____Anxiety | ____Ulcers | ____Tremors | ____Numb/Tingling in Arms/Hands |
| ___ Lower Back Pain | ____ADD/ADHD | ____Digestive Issues | ____Disc Problems | ____Numb/Tingling in Legs/Feet |
| ____Hip/Leg Pain | ____Loss of Balance | ____Diarrhea | ____Scoliosis | ____Stomach Problems |
| ____Knee Pain | ____Depression | ____Constipation | ____Poor Posture | ____High/Low Blood Pressure |
| ____Foot Pain | ____Allergies | ____Bed Wetting | ____Skin Problems | ____Difficulty Breathing |

Other:_____

**Please mark "P" if in the past OR "C" if currently struggle with:**

____Stroke ____Cancer ____Heart Attack ____Spinal Surgery ____Spinal Bone Fracture
____Scoliosis ____Diabetes ____Arthritis ____Seizures ____Other Conditions

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

List all over the counter & prescription medications you are on, & the reason for each:

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? □ Yes □ No Explain _____

Fractured A Bone? □ Yes □ No Explain: _____

Other trauma: _____

## Social History

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never
4. Have you consumed any caffeine or products with caffeine in the past 48 hours? □ Yes □ No

## Quadruple Visual Analogue Scale

Circle the number that best describes the question asked. If you have more than 1 complaint, answer *each question for each individual complaint* listed on page 1 and indicate the corresponding letter from page 1 above the line.

Example: _____A_____B_____C_____

0 1 2 3 4 5 6 7 8 9 10

1. What is your pain level at its BEST? (How close to 0 does your pain ever get?)

0 1 2 3 4 5 6 7 8 9 10

2. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

3. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST? (How close to 10 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

## Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITY: | EFFECT: | | | |
|---|---|---|---|---|
| Walking | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Driving | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Climbing Stairs | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Static Sitting | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Static Standing | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Sit to Stand | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Household Chores | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Lifting | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Dressing | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Sleep | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Pet Care | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Extended Computer Use | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Carrying Groceries | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Washing/Bathing | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Yard work | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Exercising | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Concentration (Reading) | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Other: | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |
| Other: | ◯ No Effect | ◯ Painful (can do) | ◯ Painful (limits) | ◯ Unable to Perform |

## Health Goals

Please list your two main health goals that you would like to achieve while under care in this office:

1. _____

2. _____

## Family Health History

This form is to assist the doctors by providing past health history information for their review.

| CONDITION | MOTHER | FATHER | SON | DAUGHTER |
|---|---|---|---|---|
| Headaches | | | | |
| Neck Pain | | | | |
| Shoulder Pain | | | | |
| Back Pain | | | | |
| Hip/Leg Pain | | | | |
| Arthritis/Joint Pain | | | | |
| Ear Infections | | | | |
| Hearing Loss | | | | |
| Dizziness | | | | |
| Loss of Energy | | | | |
| Anxiety | | | | |
| ADD/ADHD | | | | |
| Depression | | | | |
| Allergies | | | | |
| Sinus Issues | | | | |
| Asthma | | | | |
| High/Low Blood Pressure | | | | |
| Stomach Problems | | | | |
| Infertility | | | | |
| Bed Wetting | | | | |
| Sciatica | | | | |
| Sleep Problems | | | | |
| Stroke | | | | |
| Heart Disease | | | | |
| Cancer | | | | |

## X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD or USB will be available within 72 business hours for the customary charge of supplies and time required for copying. Please note x-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Vital Performance Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below you are agreeing to the above terms and conditions.

*Print Name:_____ *Date of Birth: _____

*Signature:_____ *Date: _____

**FEMALES ONLY:** To the best of my knowledge**, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Vital Performance Chiropractic.**

*Signature:_____ *Date: _____

## Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- ☐ I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- ☐ I authorize and request payment of insurance benefits directly to Dr. Dustin Bosson D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

*Print Name: _____

*Signature: _____ *Date: _____

### Written Consent for A Child

**If this health profile is for a minor/child, please fill out and sign below:**

Name of practice member who is a minor/child: _____

I authorize Dr. Dustin Bosson and any and all Vital Performance Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Vital Performance Chiropractic.

Guardian Signature: _____ Date: _____

Relationship to minor/child: _____

## Financial Policy

As a courtesy, Vital Performance Chiropractic verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. It is the policy of Vital Performance Chiropractic that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. At the conclusion of your visits, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly. If you are covered by health insurance with chiropractic benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy.

Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. All above guidelines apply to patients seeking to pay out of pocket as well. Vital Performance Chiropractic reserves the right to place a 25% late fee on all unpaid balances after 60 days of non- payment to cover their costs of a collection's agency.

## Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Dustin Bosson DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

I acknowledge and agree to the above terms and regulations and certify that I, myself, will be responsible for fees accrued in this office.

*Signature:_____ *Print:_____ *Date:_____

## Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

*Signature:_____ *Date:_____

## Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic **:**

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.

E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

- By my signature below, I have read and fully understand the above statements.
- All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

*Signature:_____ *Date: _____

## Quality of Life Survey

Please take time to thoughtfully answer the questions below so we can help you heal.
(Check all that apply)

1. **How have you taken care of your health in the past?**
   - ◯ Medications ◯ Nutrition/Diet ◯ Exercise
   - ◯ Emergency Rooms ◯ Holistic Care ◯ Chiropractic
   - ◯ Routine Medical ◯ Vitamins ◯ Other _____

2. **How did the previous method(s) work for you?**
   - ◯ Bad results ◯ Did not get worse ◯ Nothing Changed
   - ◯ Some results ◯ Did not work very long ◯ Other _____
   - ◯ Great results ◯ Still trying

3. **How have others been affected by your health condition(s)?**
   - ◯ No one is affected ◯ They must help me a lot
   - ◯ Haven't noticed any issues yet ◯ They tell me to do something about it

4. **What are you afraid this might be affecting? (Or will affect in the future if not helped)**
   - ◯ Job ◯ Sleep ◯ Self-esteem
   - ◯ Kids ◯ Time ◯ Social life
   - ◯ Future ability ◯ Finances ◯ Hobby's
   - ◯ Marriage ◯ Freedom ◯ Happiness