# Welcome to Vinings Spine & Health Center

In order to serve you best we would like to know more about you and your health history.
Please print clearly and fill this out completely prior to your appointment time.

## Patient Information

Date: _____ Male/Female (circle one)

Name:_____

Nickname:_____

Address:_____

City:_____ State:_____Zip:_____

Birth date: _____ Age:_____

Marital Status: Single Married Widowed Divorced

Occupation: _____

Employer:_____

## Patient Family Information

Spouse Name: _____

Spouse Employer:_____

Children:

Name:_____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

## Contact Information

Home Phone: _____

Work Phone:_____

Cell Phone:_____

Email: _____@_____

## Insurance

Do you have Health Insurance?.....Yes / No
Company _____
Member/ID#_____
Group# _____

Is your spouse the Primary Insured?.....Yes / No
Name _____
Company_____
Policy#_____

Are you covered by Medicare?.....Yes / No
Medicare#_____

**Whom may we thank for Referring you?**

## Patient Condition

Reason for Visit: _____

When did your symptoms appear?_____

Is your condition getting progressively worse?_____

Rate the severity of your condition: 0 (least) to 10 (worst) _____

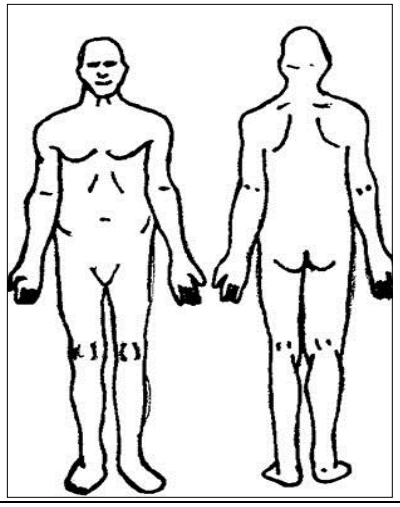
Type of Pain: **Sharp Dull Burning Throbbing Numbness Cramping Tight**

Frequency of Pain: **Constant Come and Go**

Does it interfere with: **Work Sleep Daily Routine Recreation**

Activities that are most painful:_____

Put an "X" on the picture where you have pain, numbness or tingling.



# Health History

Have you ever seen a chiropractor before?_____ Approximate last adjustment date:_____

Reason for the chiropractic care: _____

Names of other doctors who have cared for you: _____

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan:_____

There are many indicators for possible subluxation. Please circle any of the conditions you have suffered from in the **last 6 months**.

| | | | | |
|---|---|---|---|---|
| Depression | High Blood Pressure | High Cholesterol | Thyroid-problems | Headaches/Migraines |
| Sinus Issues | Heart Conditions | Breathing Problems | Digestive Problems | Bowel Problems |
| Urinary Problems | | Liver Problems | Other:_____ | |

**Medications and Supplements** you are taking:

_____

_____

Do you smoke?_____ Packs/Day_____ Drink Alcohol?_____ Drinks/Week_____

Drink Coffee/Caffeine? _____ Cups/Day_____ High Stress Level (physical, mental, spiritual)? _____

Reason:_____

Other: _____

Recreational Activities you participate in: _____

Recreational Activities as a child: _____

**For Women Only:** Are you pregnant? Yes No Due Date:_____

I certify that to the best of my knowledge I am not pregnant, and the doctors and staff of Vinings Spine & Health Center have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Initial _____ Date_____

# Review of Systems

Are You Presently Suffering (Or Within The Past Six Months Suffered) From Any Of The Following? Circle all that applies. If no symptoms please circle normal.

General

| | |
|---|---|
| **Normal** | Chills |
| Fatigue | Weight Change |
| Weakness | Night Sweats |
| Fever | Other: _____ |
| Loss Of Sleep | _____ |

Neurological

| | |
|---|---|
| **Normal** | Convulsions |
| Headache | Nervousness |
| Dizziness | Other: _____ |
| Fainting | _____ |

Skin

| | |
|---|---|
| **Normal** | Eczema |
| Rash | Hair Changes |
| Redness | Nail Changes |
| Itching | Bruise Easily |
| Dryness | Other:_____ |
| | _____ |

Eyes

| | | |
|---|---|---|
| **Normal** | | |
| Vision Trouble | Left | Right |
| Pain | Left | Right |
| Discharges | Left | Right |

Other: _____

# Review of Systems Continued

Ears

**Normal**

Hearing Trouble Left Right
Ringing Left Right
Pain Left Right
Discharge Left Right
Other: _____

Nose

**Normal**
Pain
Bleeding
Sinus Problems
Infections
Absence Of Smell
Other: _____
_____

Mouth/Throat

**Normal**
Sores
Bleeding
Enlarged Glands
Absence Of Taste
Abnormal Taste
Tonsillitis
Other: _____

.Cardio-Vascular-Pulmonary (Heart/Lungs)

**Normal**
Wheezing
Difficulty Breathing
Swollen Extremities
Blue Extremities
Varicosities
Murmur
Chest Pain
Palpitations
Other: _____

Breasts

**Normal**
Lumps In Breasts
Redness/Itching
Pain
Dimpling
Discharge
Other: _____
_____

Endocrine (Metabolism)

**Normal**
Heat/Cold Intolerance
Sugar In Urine
Goiter
Tremor
Other: _____

Psychological

**Normal**
Anxiety
Depression
Memory Loss or Impairment
Phobias
Mood Swings
Other: _____

Gastrointestinal (Stomach/Digestion)

**Normal**
Decreased Appetite
Increased Appetite
Abdominal Pain
Hemorrhoids
Excess Gas
Vomiting
Diarrhea
Constipation
Other: _____

Genitourinary

**Normal**
Inability To Hold Urine
Bleeding
Painful Urination
Frequent Urination
Prostate Problems
Irregular Menstruation
Painful Menstruation
Abnormal Vaginal Area
Sterility
Impotence
Bedwetting
Other: _____
_____

# Stress History

Subluxation can often be caused by a slip, twist, fall, strain, accident, surgery and other traumas.
Please give us a brief description of any of these events you can think of and the dates.

Description Date

**Auto Accidents** (Even if you were not driving)

_____ _____
_____ _____

**Falls/ Strains** (Not limited to back injuries)

_____ _____
_____ _____

**Head Injuries/ Whiplash** (Even as a child)

_____ _____
_____ _____

# Trauma History Continued

Description Date

**Broken Bones/ Dislocations**

_____ _____

_____ _____

**Surgeries**

_____ _____

_____ _____

**Cancer**

_____ _____

_____ _____

**Any other traumas not previously listed**

_____ _____

_____ _____

# Auto Accident History

Date of Accident: ____/_____/_____
Time of Accident: _____ am/pm

1. Where your position in the vehicle?

| | |
|---|---|
| Driver | Rear Passenger |
| Front Passenger | Pedestrian |

2. What type of vehicle were you driving?

| | |
|---|---|
| Compact Car | Full Size SUV |
| Compact Truck | Bicycle |
| Compact SUV | Full Size Car |
| Motor Home | Minivan |
| Mid-Size Car | Motorcycle |
| Full Size Truck | |

3. What was your speed at the time of the accident?
(Circle all that applies

Stopped at stoplight
Merging into traffic: What was your speed?
_____
Slowing down at intersection

4. Who hit whom?

Struck by another vehicle
Struck another vehicle
Hit a stationary object

5. What was your point of imp

| | |
|---|---|
| Front | Rear Right Side |
| Rear | Rear Left Side |
| Front Right Side | Middle Right Side |
| Front Left Side | Middle Left Side |

6. What was the speed of the other vehicle?
(Circle all that applies)

Stopped at stoplight
Merging into traffic: What was your speed? _____
Slowing down at intersection
Moving Slowly

7. What was the other vehicles point of impact?

| | |
|---|---|
| Front | Rear Right Side |
| Rear | Rear Left Side |
| Front Right Side | Middle Right Side |
| Front Left Side | Middle Left Side |

8. Where you wearing a seat belt?

| | |
|---|---|
| Full lap and shoulder belt | Lap restraint |
| Shoulder restraint | Not wearing a belt |

9. What position was your headrest?

| | |
|---|---|
| Low Position | Middle Position |
| High Position | No Headrest |

# Auto Accident History Continued

10. Did your airbags deploy?

Yes No Airbags
No

11. Where you prepared for impact?

Completely Surprised
Saw it coming
Saw it coming and braced for it

12. What position was your body prior to impact?
(Circle all that applies)

Straight Tilted Forward
Rotated Right Can't remember
Rotated Left

13. What happened to your body at impact?
(Circle all that applies)

Tensed Up
Violently torque & twisted
Thrown from vehicle
Whipped violently back & forth
Pinned in vehicle
Thrown over seat
Thrown side to side
Badly cut & bruised

14. What was you mental/emotional state afterward?

Conscious
Conscious but shaken
Very angry, not unconscious or shaken
Conscious but disoriented
Unconscious

15. Was medical treatment given at the scene of the accident?
Yes / No

16. Where did you go immediately following the accident?

Hospital
Medical Doctor
Resumed Activities
Home
This office

17. If you received treatment after accident list Doctors,
Treatment received and dates:

_____
_____
_____
_____

**Please CIRCLE the body parts that struck the following vehicle parts.**

Dashboard:

Right Side of Head
Right Arm
Right Wrist
Right Knee
Right Shoulder
Right Elbow
Right Hip
Right Ankle
Left Side of Head
Left Arm
Left Wrist
Left Knee
Left Shoulder
Left Elbow
Left Hip
Left Ankle

Windshield:

Right Side of Head
Right Arm
Right Wrist
Right Knee
Right Shoulder
Right Elbow
Right Hip
Right Ankle
Left Side of Head
Left Arm
Left Wrist
Left Knee
Left Shoulder
Left Elbow
Left Hip
Left Ankle

Steering Wheel:

Right Side of Head
Right Arm
Right Wrist
Right Knee
Right Shoulder
Right Elbow
Right Hip
Right Ankle
Left Side of Head
Left Arm
Left Wrist
Left Knee
Left Shoulder
Left Elbow
Left Hip
Left Ankle

Right Door:

Right Side of Head
Right Arm
Right Wrist
Right Knee
Right Shoulder
Right Elbow
Right Hip
Right Ankle
Left Side of Head
Left Arm
Left Wrist
Left Knee
Left Shoulder
Left Elbow
Left Hip
Left Ankle

Left Door:

Right Side of Head
Right Arm
Right Wrist
Right Knee
Right Shoulder
Right Elbow
Right Hip
Right Ankle
Left Side of Head
Left Arm
Left Wrist
Left Knee
Left Shoulder
Left Elbow
Left Hip
Left Ankle

Seat Frame:

Right Side of Head
Right Arm
Right Wrist
Right Knee
Right Shoulder
Right Elbow
Right Hip
Right Ankle
Left Side of Head
Left Arm
Left Wrist
Left Knee
Left Shoulder
Left Elbow
Left Hip
Left Ankle

# Auto Accident History Continued

Unknown Object:

| | |
|---|---|
| Right Side of Head | Left Side of Head |
| Right Arm | Left Arm |
| Right Wrist | Left Wrist |
| Right Knee | Left Knee |
| Right Shoulder | Left Shoulder |
| Right Elbow | Left Elbow |
| Right Hip | Left Hip |
| Right Ankle | Left Ankle |

18. Please list any other body parts that were not listed that were injured from the accident:

_____

_____

_____

19. In addition to your bodily injuries have you experienced any of the following?:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anxiety | Convulsions | Restlessness | Depression | Dizziness | Insomnia | Mood Swings | Headaches |
| Light Sensitivity | | Nervousness | Fainting | Reduced Appetite | Poor Memory | Loss Of Balance | Weakness |
| Tension | | Fatigue | Weight Gain | Weight Loss | Other: _____ | | |

20. Are you restricted in any of the following areas as a result of this accident / injury?

Daily Living  Occupational/Work  Recreational Activities

Other: _____

21. Have you missed work due to this accident / injury?

Missed No Work  Limited Work Activity  Missed Work From:_____ to _____

22. Did you self treat your symptoms?

No  Ice  Heat  Bed Rest  Over-The-Counter-Medications

Other: _____

# Insurance / Attorney Information

1. Have you contacted an insurance adjuster or representative regarding this claim? Yes / No
   - A. Insurance Company: _____
   - B. Is this your personal Auto Insurance Co.? Yes / No
   - C. Adjuster's Name Or Team Number & Phone No.: _____ / _____
   - D. Claim Number: _____

2. Have you engaged services of an attorney? Yes / No
   - A. Attorney's Name: _____
   - B. Phone Number: _____

3. Have you filed an accident / injury report with the police? Yes / No

# Informed Consent to Chiropractic Care Continued

**The Availability And Nature Of Other Treatment Options**

Other treatment options for your condition may include:

- Self-administered over-the-counter analgesics and rest
- Medical care with prescription drugs
- Hospitalization
- Surgery

**The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:**

Overuse of over-the-counter medications produces undesirable side effects. If complete rest and impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline to not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

**The Risks And Dangers Attendant To Remaining Untreated**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associates. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

_____ _____

Signature of Patient Printed Name of Patient

## PAYMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Vinings Spine & Health Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I also understand that if I accumulate an account balance I am responsible for paying it in full within 30 days, otherwise my account will be charged a $15 late fee and this balance will be subject to a 20% interest rate until the balance is brought to $0. Returned checks are subject to a fee of $25. If any balance goes more than 60 days overdue, the credit card I have on file will be charged the remaining balance.

_____ _____

Signature of Patient Printed Name of Patient

# Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

***Adjustment:*** **An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.**

***Health:*** **A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.**

***Vertebral Subluxation*****: A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.**

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY PRACTICE OBJECTIVE*** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

I understand if I have any questions I am able to ask the doctors, their associates and staff.
I, therefore, accept chiropractic care on this basis.

_____ _____

Signature Date

I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-ray to fully evaluate my condition for the presence of vertebral subluxation.

**Patient Signature**_____ **Date**_____

(If patient is under 18, Signature of Legal Guardian)

**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information. A complete copy of this document is available upon request.

**Patient Signature**_____ **Date**_____

(If patient is under 18, Signature of Legal Guardian)

- I give permission to use my photo in the office as witness and celebration of my wellness.
- I give permission for my name to be recorded as a means for me to be called to my adjustment.
- I give permission to use my name in the office if I refer a new member to the practice.
- I understand that if I am chosen as Patient of the Week, I give permission for certain information about my case to be disclosed in the office.
- If I choose to give a testimonial of my experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

**Patient Signature**_____ **Date**_____

(If patient is under 18, Signature of Legal Guardian)