CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name ______________________________
LAST NAME

____
FIRST NAME MIDDLE INITIAL

Address ______________________________

City______________State _____ Zip Code _______

Home Phone ______________________________

Cell Phone ______________________________

Email ______________________________

Sex ☐ M ☐ F Age ___ Birthday____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School ______________________________

Occupation______________________________

Spouse's Name ______________________________

Spouse's Employer ______________________________

Spouse's Occupation ______________________________

IN CASE OF EMERGENCY, CONTACT

Name______________________________

Relationship______________________________

Contact Number ______________________________

Who may we thank for referring you? ______________________

HOW CAN WE HELP YOU?

What brings you in today? ______________________________

____

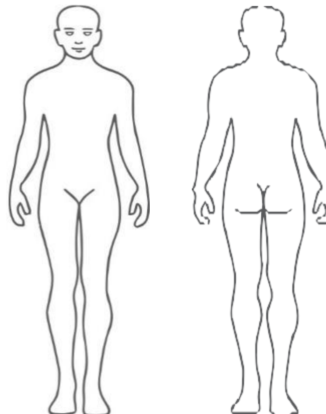
If you are already experiencing a symptom, what is it? ______________________________

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other ________________

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

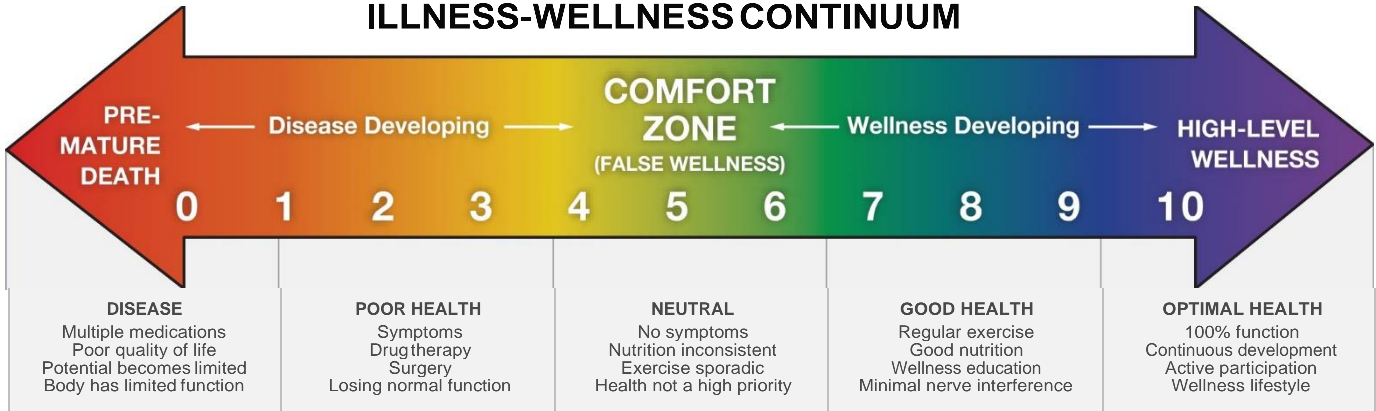
	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other ___________	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? ______________________

B. In what direction is your health currently headed? ______________________

What are your health goals?

IMMEDIATE ______________________

SHORT TERM ______________________

LONGTERM ______________________

CHILDREN & PREGNANCY

How many children do you have? ______________________

Childrens' ages? ______________________

Childrens' health concerns? ______________________

Are you currently pregnant? ☐ No ☐ Yes, I am due ______________

Number of past pregnancies? ______________________

Health concerns regarding this pregnancy? ______________________

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other ______________

____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

____

____

____

MEDICATIONS (list)

____

____

____

SUPPLEMENTS (list)

____

____

____

CHIROPRACTIC OBJECTIVES

When a patient seeks health care and we accept a patient for care, it is essential for both parties to be working toward the same objectives.

Chiropractic care has only one goal and that is to eliminate misalignment within the spinal column which interferes with the expression of the body's innate wisdom. It is important that each patient understands both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments 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 vertebrae in the spinal column which causes alteration of nerve function and the interference to the transmission of mental impulses, resulting in lessening of the body's God-given ability to express its maximum health potential.

We do not diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek services of a health care provider who specializes in that area. Regardless of what the disease may be called, we do not offer to treat it nor do we offer advice regarding the treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate major interference to the expression of the body's God-given wisdom. Our only method is specific adjustment to correct vertebral subluxation.

I, ________________________, have read and fully understand the above statement.
(Patient Full Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis. ______________________________ Date: __________
(Patient Signature)

CARE SELECTION

Most patients seeking chiropractic care have one of two objectives in mind concerning their healthcare - some patients seeking symptomatic relief of pain or discomfort (**RELIEF CARE**) while others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**CORRECTIVE CARE**). During your first appointment, your doctor will focus on your needs and your objectives as we discover a plan that will work best for you.

☐ **RELIEF CARE** provides relief from symptoms or pain, but does not correct the cause. Initial issue is likely to return

☐ **CORRECTIVE CARE** differs from relief care in that the goal is to get rid of symptoms **AND correct the cause.**

ASSIGNMENT OF BENEFITS & RELEASE

- I hereby irrevocably assign to Vital Health Chiropractic Center the rights and benefits under any policy of insurance, indemnity agreement or any other collateral source as defined in the Florida Statutes for any service or any charges provided by Vital Health Chiropractic Center | Vital Health of the Palm Beaches. This assignment includes any right to sue said insurance companies for any payment of my chiropractic bills.
- I authorize release of information to family physicians and employer.
- I authorize release of information to insurance companies.
- I authorize the taking of photographs and x-rays to be used for treatment purposes.
- I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
- I authorize my insurance benefits to be paid directly to:
  Vital Health Chiropractic | Vital Health of the Palm Beaches
  411 7th Street, West Palm Beach, Fl 33401 | 561-835-3556
- I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment any fees for professional services rendered me will IMMEDIATELY become due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect these fees.

Patient Signature: _______________________________________ Date: _______________

Guardian Signature: _____________________________________ Date: _______________

CONSENT TO TREAT A MINOR

I hereby authorize Vital Health Chiropractic Center | Vital Health of the Palm Beaches to administer treatment as they so deem necessary to my Son/Daughter/Other (Name)______________________________ Date: _______________

Witness: ____ Date: _______________

PREGNANCY RELEASE

This is to certify that the the best of my knowledge I am not pregnant and Dr. Mark W. Ashley and his associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _______________

Patient Signature: _______________________________________ Date: _______________

INSURANCE PATIENT DISCLOSURE

PLEASE NOTE: You may receive check payments from your insurance company for services rendered by Vital Health Chiropractic Center | Vital Health of the Palm Beaches. These checks must be endorsed and delivered to Vital Health Chiropractic Center immediately with all statements and correspondence included.

I, ____, the patient of Vital Health Chiropractic Center | Vital Health of the Palm Beaches, have read and agree to the terms above prior to beginning treatment. I agree that I will be responsible for all collection agency, attorney and legal fees and or any costs if legal action become necessary to collect these fees.

Patient Name: ____

Patient Signature: ____

Social Security #: ____

Date Signed: ____