Vital Family Chiropractic—Application for Care

Date: _____

Name_____BC_____
Last Name First Name M.I. Office Use

How would you like to be addressed?_____ _____
Office Use

Address_____
Street City Zip

Home Phone_____ Mobile Phone_____

Email Address_____ Would you like to be on our mailing list? Y N

Date of Birth_____ Age_____ Male Female Marital Status S M D W

Spouse's Name_____ Number of children_____ Names_____

Social Security _____ Employer_____ Occupation_____

Employer Address_____ Work Phone_____

Who may we thank for referring you?_____

If you have seen a Chiropractor before, who was your Doctor?_____when_____

Reasons (what was bothering you)_____

Current major complaint or problem_____

How long has it been bothering you?_____

Has the problem been getting **Worse** **Better** **Same**

Who have you seen for this problem?_____

Is your injury due to a (n) **Automobile Accident** **Home Injury** **Recreation** **Work**

Are you currently taking medication? If yes, please list below (include over the counter medicine and contraceptives).

_____

Have you ever had surgery? If yes, please list the surgery and the date.

Surgery_____Date_____Surgery_____Date_____

Insurance Company_____

Vital Family Chiropractic
7504 86th St SW Suite 150 Lakewood, WA 253.212.2036

Vital Family Chiropractic
Adult Body Signals

*__Please circle any body signals that you are experiencing now or have in the past.__

Headaches
Migraines
Head Seems Heavy
Loss of Memory
Dizziness
Fainting
Tremors
Palpitation
Neck: Pain or Stiffness
Motion Restriction
Upper Back: Pain or Stiffness
Lower Back: Pain or Stiffness
Pins and Needles in Arms
Numbness in arms or legs

Digestive Disorder
Frequent Urination
Nausea
Constipation
Diarrhea
Extreme Fatigue
Shortness of Breath
Poor Posture
Radiating Pain to: right arm, left arm, right leg, left leg, hips, shoulders,
High Blood Pressure
Pins and Needles in Legs

Menstrual Discomfort
Menstrual Cramping
Diabetes
Ringing in Ears
Swollen Joints
Difficulty: lifting, walking, sitting bending
Sinus: congestion, drip, pressure
Insomnia
Eye Strain
Pain behind eyes

Fees are due and payable at the time of examination, x-rays and adjustments unless other arrangements are made in advance. The fee paid for x-rays is for analysis only. The film itself is the property of the office. Once films are used for care purposes they cannot be released directly to the patient. However, they may be released to another physician with the properly signed release and must be returned to this office within 14 days of the release.
I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that Vital Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company. Also, any amount to be paid directly to Vital Family Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am responsible for payment. I also understand that the promotion for new patient exam is 25.00 and covers a minimal exam. In the event that a more comprehensive exam is needed there may be an additional charge.

_____ _____

Patient Signature Date

In case of emergency, please notify:

Nearest relative not living with you_____Phone_____

Address_____
Street City Zip

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

_____ _____/_____/_____

(Signature) (Date)

Vital Family Chiropractic Privacy Authorization

We strive to make your experience with us exceptional. Howerever, due to new laws passed to protect your privacy we request in writing your authorization to proceed with certain office practices. Your signature below will verify that (1) you have read the following procedures and do not object and (2) you have been given a notice of our privacy practices and an opportunity to review them.

☐ We welcome new patients and thank referrals with their names on a dry erase board at the front desk.
We use postcards and to wish you happy birthday, welcome you and remind you of an appointment.
☐ We may mail health articles, newsletters and other information directly to your home or email.
☐ We may leave a message at your home with someone or on an answering machine.
☐ We post pictures of our "Chiropractic Kids" in the kid's area and "Chiropractic Families" on the Family boards.
☐ Should you share a written testimonial with us, we may display it in binders or use it in our advertising.
☐ You will receive your chiropractic adjustments in an open adjusting area with half walls.

_____ _____/_____/_____

(Signature) (Date)

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