

Vital Family Chiropractic—Application for Care (Minor)

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 _____ Date of Birth _____ Age _____ Male Female

Parents Names _____

(Mother)

(Father)

Mother's Employer _____ Father's Employer _____

Occupation _____

Occupation _____

Address _____

Address _____

Phone _____

Phone _____

Who may we thank for referring you? _____

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

Reasons (what was bothering your child) _____

Current major complaint or problem _____

How long has it been bothering your child? _____

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

Who has your child seen for this problem? _____

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

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

Has your child ever had surgery? If yes, please list the surgery and the date.

Surgery _____ Date _____

Surgery _____ Date _____

Insurance Company _____

Vital Family Chiropractic

Adult Body Signals

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

Headaches	Digestive Disorder	Menstrual Discomfort
Migraines	Frequent Urination	Menstrual Cramping
Head Seems Heavy	Nausea	Diabetes
Loss of Memory	Constipation	ringing in Ears
Dizziness	Diarrhea	Swollen Joints
Fainting	Extreme Fatigue	Difficulty: lifting,
Tremors	Shortness of Breath	walking, sitting
Palpitation	Poor Posture	bending
Neck: Pain or Stiffness	Radiating Pain to: right arm,	Sinus: congestion,
Motion Restriction	left arm, right leg, left leg,	drip, pressure
Upper Back: Pain or Stiffness	hips, shoulders,	Insomnia
Lower Back: Pain or Stiffness	High Blood Pressure	Eye Strain
Pins and Needles in Arms	Pins and Needles in Legs	Pain behind eyes
Numbness in arms or legs		

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.

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. However, 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)

Vital Family Chiropractic
7504 86th St SW Suite 150 Lakewood, WA 98498 253.212.2036