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.
Every question MUST have an answer. If the question does not apply to you please mark **N/A** so that we know you acknowledged the question.

Patient Information

Date: _________________ Male/Female (circle one) Birthdate: ______________________ Age: ____

Name:____ Nickname:___________________________________

Address:_______________________________________ City:_________________ State:______ Zip:________

Cell Phone:____________________________________ Work Phone:______________________________

Home Phone: __________________________________ Email: ____________________@________________

Occupation: __________________________________ Employer:__________________________________

Marital Status: Single Married Widowed Divorced

Social Security# (**BCBS Only**)______________________________

Referred By: _______________________________ Ethnicity:_________________________________

Medical Insurance Company: ____________________ Phone #: _____________________________________

ID/Member #: ___________________________________ Plan #/Group #: ___________________________

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** **Frequently** **Occasionally**

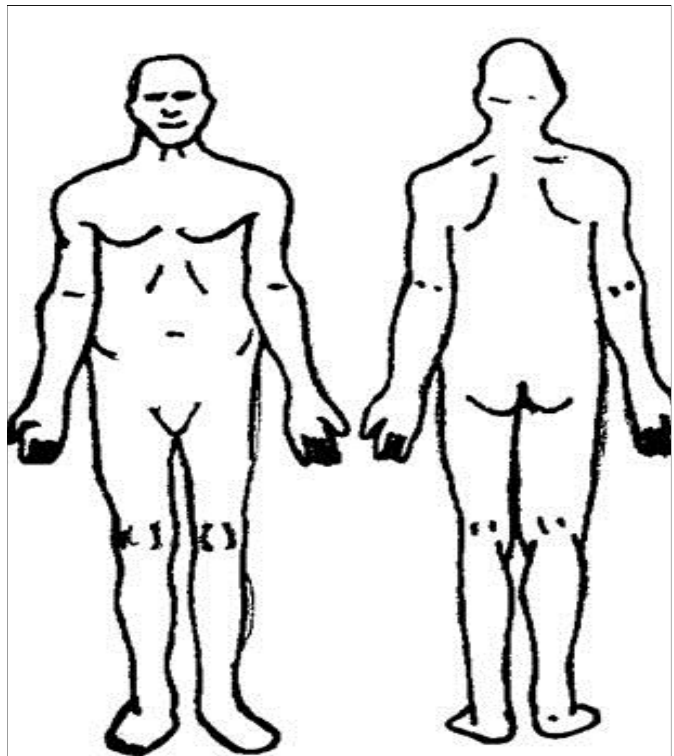
Does it interfere with:

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:__________________		**NONE OF THE ABOVE**

Medications and Supplements you are taking:

____

____

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 none of the choices apply circle **Normal.**

General

Normal

Weight Change
Night Sweats
Loss Of Sleep
Fatigue
Weakness
Other: _____________
____

Neurological

Normal

Headache
Dizziness
Fainting
Nervousness
Other: ____________
____

Skin

Normal

Rash
Nail Changes
Bruise Easily
Eczema
Other:_____________
____

Eyes

Normal

Vision Trouble Left Right
Pain Left Right
Other: ______________________________

Review of Systems Continued

Ears

Normal

Hearing Trouble Left Right

Ringing Left Right

Other: ______________________________

Nose

Normal

Infections

Absence Of Smell

Sinus Problems ____________________

Other ______________________

.Cardio-Vascular-Pulmonary (Heart/Lungs)

Normal Varicosities

Wheezing Murmur

Difficulty Breathing Chest Pain

Swollen Extremities Palpitations

Blue Extremities

Other: ____________________

Psychological

Normal

Phobias

Anxiety

Mood Swings

Depression

Memory Loss or Impairment

Other: ______________

Gastrointestinal (Stomach/Digestion)

Normal Excess Gas

Decreased Appetite Vomiting

Increased Appetite Diarrhea

Abdominal Pain Constipation

Hemorrhoids

Other: ______________

Genitourinary

Normal

Painful Menstruation

Inability To Hold Urine

Painful Urination

Frequent Urination

Prostate Problems

Irregular Menstruation

Other: ______________

Stress History

Subluxation can often be caused by a slip, twist, fall, strain, accident, surgery and other stresses.
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)

____ ________________________

____ ________________________

Stress History Continued

	Description	Date
Broken Bones/ Dislocations		
	______________________	______________
	______________________	______________
Surgeries		
	______________________	______________
	______________________	______________
Cancer		
	______________________	______________
	______________________	______________
Any other Stress not previously listed		
	______________________	______________
	______________________	______________

Informed Consent to Care

Patient: Please discuss any questions or concerns with the doctor and/ or associates.

I hereby request and consent to the performance of Physical Medicine and chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by the doctor, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “pop” your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients may feel some stiffness and soreness following the first few days of treatment.

The Probability Of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, the doctor will look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as “rare”.

Ancillary Treatment

In addition to Physical medicine, you may be given home instructions to use the following treatments, with the associated risks:

- Heat ~ risk of 1st and 2nd degree burns, hemorrhage
- Cryotherapy (cold packs) ~ risk of skin reactions
- Trigger Point Therapy ~ risk of bruising, release of emboli
- Massage ~ risk of deep vein thrombosis

Informed Consent to 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 is 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 (If patient is under 18, Signature of Legal Guardian)	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 and 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 (If patient is under 18, Signature of Legal Guardian)	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
(If patient is under 18, Signature of Legal Guardian)

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 and on our website 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 Month, I give permission for certain information about my case to be disclosed in the office. (We will discuss the matters of what would be disclosed to you before presenting it 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. (Never at any time will your entire name be displayed in our office or identifying information of you.)

Patient Signature____ **Date**____________________________
(If patient is under 18, Signature of Legal Guardian)