PRACTICE MEMBER INFORMATION

Date:_____

Name:_____ **Home** Phone:_____ **Cell** Phone:_____

Age:_____ **DOB**:_____ M F **Marital** Status: S M D W **E-mail** address:_____

Address:_____ **City**:_____ **Zip**:_____

Occupation:_____ **Employer**:_____ **Spouses** Name:_____

Spouses Employer:_____ **Children's** Names/Ages:_____

Who referred you?_____ **Have** you ever received chiropractic care? □ Yes □ No

What have you heard about Chiropractic?_____

The most common postural weakness is Forward Head Syndrome. This happens when the head and neck start to bend forward and progressively move downward weakening the whole body. Even less severe forms of this posture can cause many adverse effects on your overall health.

Are you aware of any poor posture habits or that you carry your head forward? □ Yes □ No

ADDRESSING THE ISSUE THAT BROUGHT YOU TO US

If you have no complaints but are here for wellness services, please skip to the next section.

Please describe the complaint that brought you to our office:_____

_____

Is your pain, □ Sharp □ Dull □ Numb □ Throbbing □ Travels **Does** it affect you □ Constantly or □ Occasionally

It interferes with: □ Hobbies or Sports □ Work (responsibilities, tasks, duties) □ Social Time (kids, spouse/friends)

What have you tried? □ Ice/Heat □ Stretching/Exercise □ Vitamins □ Medications □ Changed Diet □ Aspirin/Tylenol etc.

YOUR HEALTH LIFESTYLE

	YES	*NO*	
Do you exercise? What & How often/week?	□	□	_____
Do you buy pure water? How much do you use?	□	□	_____
Do you use vitamins or supplements? What?	□	□	_____

On a scale of 1-10 describe your stress. (0=none, 10=extreme) Occupational_____ Personal_____

On a scale of Poor, Good, Excellent describe your: Diet_____ Sleep_____

REVIEW OF TRAUMAS AND STRESSORS

Throughout life, events occur which damage the expression of health causing alterations of posture, function or neurological health. This case history will uncover layers of damage that resulted in poor health.

	Yes	*No*	*If Yes, please provide comments:*
***D**id you have any childhood illnesses?*	□	□	_____
***D**id you have any surgeries?*	□	□	_____
***H**ave you fallen from a height over three feet?*	□	□	_____
***W**ere you involved in any car accidents?*	□	□	_____
***H**ave you had prolonged use of medicine?*	□	□	_____
***H**ave you suffered any traumas or fractures?*	□	□	_____

List any medications you are taking, the reason and the doses:_____

_____

HEALTH CONDITIONS

Abnormal *postural habits or distortions cause kinks in vertebrae of the spine and are the result of trauma or stress to the body. When these vertebrae are twisted from their normal healthy position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These kinks in the spine are called Subluxations (sub-lux-a-shuns).*

Subluxations *weaken and distort the overall structure of your spine resulting in a weakened and distorted posture. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).*

Neck (Cervical Spine):

Postural distortions from ***Subluxations****, (causing* ***Forward Head Syndrome****), in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Have you experienced…?*

□ Neck Pain	□ Visual Problems	□ Sinusitis	□ Dizziness	□ Headaches
□ Allergies	□ Recurrent Colds/Flu	□ Weak Grip	□ Low Energy/Fatigue	□ Hearing Disturbances
□ TMJ Pain	□ Thyroid Conditions	□ Cold Hands	□ Pain in arms/hands	□ Numbness/tingling in arms/hands

Upper and Middle Back (Thoracic Spine):

Postural distortions from ***Subluxations****, (resulting from* ***Forward Head Syndrome****), in your upper and middle back will weaken the nerves to the heart, lungs, ribs, chest and upper digestive tract and affect these parts of your body. Do you experience…?*

□ Heart Palpitations	□ Recurrent lung infections/bronchitis	□ Mid Back Pain	□ Pain into your Ribs/Chest
□ Heart murmurs	□ Pain on deep inspiration/expiration	□ Asthma/wheezing	□ Hypoglycemia
□ Tachycardia	□ Shortness of breath	□ Indigestion/Heartburn	□ Reflux
□ Heart attacks/Angina	□ Tired/Irritable when you haven't eaten	□ Ulcers/Gastritis	□ Nausea
□ High Cholesterol	□ Tired/Irritable after eating	□ Altered Liver Function	

Lower Back (Lumbar Spine):

Postural distortions from ***Subluxations*** *in the low back (resulting from* ***Forward Head Syndrome,****) weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?*

□ Low Back Pain	□ Muscle cramps in your legs/feet	□ Constipation/Diarrhea
□ Pain into your hips/legs/feet	□ Weakness/injuries in your hips/knees/feet	□ Menstrual irregularities/cramping
□ Frequent/difficulty urinating	□ Numbness/tingling in your legs/feet	□ Recurrent bladder infections
□ Sexual dysfunction	□ Coldness in your legs/feet	

I certify that I have filled out the above Health Profile in an honest and complete manner.

Patient Name:_____ Signature:_____Date:_____

For training and safety of our practice members and employees, camera surveillance equipment is being used. This equipment may or may not be monitored at any time. Surveillance cameras will be utilized only in public areas where there is no "reasonable expectation of privacy" or clearly marked in two consultation rooms. Public areas may include reception area; building entrances; hallways; and/or where employees and patients come and go. Surveillance cameras will not be installed in "private" areas such as restrooms, changing areas, x-ray suite, or private offices.

Signature:_____ Date:_____

I allow Vitality Chiropractic to share my clinical progress and significant findings with my primary care physician to allow for excellent integrity of care.

Dr._____ Address:_____

City:_____ Zip:_____

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____Date:_____

Witness Name:_____ Signature:_____Date:_____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Onset of last menstruation:_____ _____ _____

(*Signature)* (Date)

Vitality Chiropractic, P.C. Rob Anderson, D.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-15-2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time; such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using you our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up chiropractic supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials heath information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, there will be a charge per item.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.

Contact: Rob Anderson, D.C. Phone: 303-346-7095 Fax: 303-346-7097 Address: 541 W. Highlands Ranch Parkway, Suite 104, Highlands Ranch, CO 80129

I hereby certify that I have received a copy of this notice.

_____ _____

Signature Date