T 1 2 3 Date___/___/_____

VERO CHIROPRACTIC

New Practice Member Paperwork

Name_____ Date of Birth____ /_____ /_____ Age_____ Male/Female

Address_____ City_____ State_____ Zip_____

Phone: Cell_____ Home_____ Email Address_____

Occupation_____ Employer's Name_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages, & Gender_____

How did you hear about us?_____

List The Health Concerns That Brought You Into This Office

Health Concern: List according to severity	Rate of Severity 0 = no issues 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	_____
Second:_____	_____	_____	_____	_____	_____
Third:_____	_____	_____	_____	_____	_____
Fourth:_____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who and when?_____

Name of primary care physician:_____

Please Mark "P" For In The Past, Mark "C" For Currently Have or "N" for Never:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Numb/Tingling Arms/Hands (L/R)
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Menstrual Problems	___ Numb/Tingling Legs/Feet (L/R)
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Prostate Problems	___ Stroke
___ Neck Pain	___ Dizziness	___ Asthma	___ Sexual Dysfunction	___ Heart Attack
___ Shoulder Pain (L/R)	___ Loss of Energy	___ Difficulty Breathing	___ Infertility	___ Heart Problems
___ Elbow/Wrist Pain	___Sleep Problems	___ Nausea	___ Seizures	___ High/Low Blood Pressure
___ Upper Back Pain	___ Double/Blurry Vision	___ Ulcers	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Stomach Issues	___ Tremors	___ Chest Pain
___ Lower Back Pain	___Nervousness	___ Digestive Issues	___ Disc Problems	___ Cancer
___ Hip/Leg Pain (L/R)	___ Depression	___ Diarrhea	___ Scoliosis	___ Spinal Bone Fracture
___ Sciatic Pain (L/R)	___ Loss of Balance	___ Constipation	___ Poor Posture	___ Spinal Surgery
___ Knee Pain (L/R)	___ ADD/ADHD	___ Bed Wetting	___ Skin Problems	___ Diabetes (Type 1 or 2)
___ Foot Pain (L/R)	___ Allergies	___ Bladder Problems	___ Arthritis/Joint Pain	___ Fibromyalgia

Other Conditions/Diseases:_____

List all surgical operations & years:_____

List any other injuries to your spine, minor or major, that the doctor should know about:_____

_____

List all over the counter & prescription medications you are on, & the reason for each:_____

_____

Have you ever been in an auto accident? List all:_____

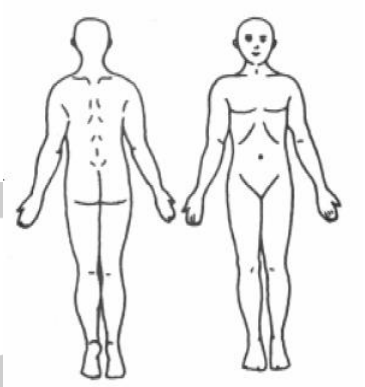
Have you ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

Other trauma:_____

Social History

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never
4. Have you consumed any products with caffeine in the past 48 hours? □ Yes □ No



***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Outcome Assessment Tool

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Headaches Low Back Pain

1. How would you rate your pain **RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or **AVERAGE** pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are a part of your life:

ACTIVITY:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Objects	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting for Long Periods	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing for Long Periods	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Health History

This form is to assist the doctors by providing past health history information for their review.

Please check the appropriate boxes

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
NAME OF FAMILY MEMBER					
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Alzheimer’s					

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, this will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care, and give consent to the examination and chiropractic care that the doctor deems necessary, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Josiah Fitzsimmons, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for all charges not covered.

Print Name: _____

Signature: _____ **Date:** _____

If This Health Profile Is for A Minor/Child, Please Fill Out and Sign Below

Written Consent for A Child

Name of Practice Member who is a Minor/Child: _____

I authorize Dr. Josiah Fitzsimmons and any and all Vero Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Vero Chiropractic.

Guardian Signature: _____ **Date:** _____

Relationship to Minor/Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature: _____ **Date:** _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Vero Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Vero Chiropractic.

Signature: _____ **Date:** _____