



PATIENT APPLICATION FORM

We specialize in assisting our patients achieve their highest level of health through our spinal postural corrective programs. Our approach is unique and advanced from other rehabilitation programs. This allows our patients to achieve far superior results compared to most other systems.

Please, fill out the following information thoroughly so the doctor can let you know if you are in a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Patient Name: _____

Date: _____



PATIENT APPLICATION SURVEY

Full Name _____
 Date of Birth _____
 Email _____
 Address _____
 Mobile Phone _____
 Occupation _____
 Emergency Contact _____
 Who should we thank for referring you to us? _____

Today's Date _____
 Social Security Number _____ - _____ - _____
 ITIN Number _____ - _____ - _____
 City _____ State _____ Zip Code _____
 Gender: Female Male
 Civil Status: Single Married Divorced Widow
 Emergency Phone _____

PURPOSE OF THIS VISIT

Health Issue	Date Condition Started	Frequency	Severity 0-10
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____

Are there conditions getting worst? YES NO Is this: Constant Frequent Occasional Activity Related

How would you describe you pain or discomfort (check all that apply)

- Dull Achy Throbbing Stiff Sharp Stabbing Shooting
 Intense Burning Constricting Other (please describe) _____

Does your condition interfere with:

- Work Sleep Hobbies Daily Routine (please describe) _____

What activities aggravate your symptoms?

- Coughing Sneezing Bearing Down Lifting Bending Pushing Pulling
 Driving Sitting Walking Running Standing Laying Down Movement

Is there anything, which has relieved your symptoms? YES NO

- Ice Heat Massage Resting Exercise Sitting Standing
 Bracing/Taping Stretching 'Popping' Joints Laying Other _____



PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? Yes No If yes, where? _____

Do you experience any numbness and tingling anywhere? Yes No If yes, where? _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? Yes No Who? _____ When? _____

Reasons for visits: _____

Did your previous chiropractor take before and after x-rays? Yes No

Did you know posture determines your health? Yes No

Are you aware of any of your poor posture habits? Yes No

Please explain: _____

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

Have you ever been told or felt like carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

HEALTH LIFESYCLE

Do you exercise? Yes No How often? 1x 2x 3x 4x 5x per week Other: _____

What activities? Running/Walking Weight Training Cycling Yoga/Pilates Other: _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much per week? _____

Do you drink coffee? Yes No How many cups per day? _____

Do you take energetic drink? Yes No How much per week? _____

Do you take any supplements, vitamins, minerals, herbs? _____

Health conditions

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations. It has been extensively documented that the subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortions is called forward head syndrome (a "hunched forward" posture standing in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.



HEALTH LIFESTYLE (continued)

CERVICAL SPINE (NECK)

Postural distortions from subluxations (causing Forward Head Syndrome) in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> TMJ/Pain/Clicking | <input type="checkbox"/> General Fatigue |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Low Metabolism |
| <input type="checkbox"/> Skin Issues-Acne/Dryness | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Difficulty Focusing/AHDH | <input type="checkbox"/> Difficulty losing weight |
| <input type="checkbox"/> Recurrent Colds/Flu | <input type="checkbox"/> Weakness in Grip | <input type="checkbox"/> Coldness/Sweating in hands | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Pain into your Shoulders Arms/Hands | | <input type="checkbox"/> Hormonally agitated | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Numbness/Tingling in Arms/Hands | | | |

What is your favorite position while sleeping? Lying up Lying down Lying on left side Lying on right side

How old is your pillow? _____ How old is your mattress? _____ It is firm or soft?

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in your upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart palpitation | <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart attacks/angina |
| <input type="checkbox"/> Recurrent lung infections/bronchitis | | <input type="checkbox"/> Pain on deep inhalation/exhalation |

THORACIC SPINE (MILD BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in your mid back will weaken the nerves into the ribs/chest and upper digestive tract and affect these parts of your body. Do you experience:

- | | | |
|--|---|--|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion/Heartburn |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten | |

LUMBAR SPINE (LOW BACK)

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

- | | |
|---|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infection |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/Difficulty Urinating |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Constipation/Diarrhea/Gassiness/Bloating | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Menstrual irregularities/cramping (females) |

Please list any health conditions not mentioned: _____



AUTHORIZATION AND PRIVACY

AUTHORIZATION CASE

I authorize and agree to allow the doctor to work with my spine using spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. The doctor will not be held responsible for any health conditions, or diagnoses which are pre-existing given by another health care practitioner or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered.

Patient's Name (Please Print)	Date	Patient's Signature
Minor's Name (Please Print)	Date	Guardian's Signature

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES VITAE CHIROPRACTIC CLINIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Vitae Chiropractic Clinic to use my name, address, phone numbers and clinical records to contact me with voicemail/text/email reminders, birthday cards, holiday related cards, health related email and text messages, and information about treatment alternatives or other health related information as well as any advertisements, newsletters, or patient of the week/month postings. I give permission to Vitae Chiropractic Clinic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective healthcare information during my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Vitae Chiropractic Clinic permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGE OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, _____, understand and have been provided with a notice of information
Patient's Name (Please Print)
practices that provide me a more complete description of information uses and disclosures, I understand that I have the following right and privileges:

The right to review the notice prior to signing this consent.

The right to object to the use of my health care information for directory purposes.

The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operation.

Patient's Name (Please Print)	Date	Patient's Signature
Minor's Name (Please Print)	Date	Guardian's Signature



INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND FINANCIAL AGREEMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern affiliated with Vitae Chiropractic Clinic.

I understand that, as in the practice of medicine, in the practice of chiropractic care I do not expect that the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

Financial Agreement: I agree that in return for the services provided to me by Vitae Chiropractic Clinic I will pay my account at the time services is rendered or will make financial arrangements satisfactory to Vitae Chiropractic Clinic for payments. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any insurance policy insuring the patient or any other party liable to the patient is hereby assigned to Vitae Chiropractic Clinic. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

Vitae Chiropractic Clinic accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.

I also understand that if I cancel or fail to show up for a schedule appointment at Vitae Chiropractic Clinic, I may be charged a cancellation fee which is at the discretion of Vitae Chiropractic Clinic.

Assignment of Benefits: I agree that payments intended for Vitae Chiropractic Clinic in return for services provided to me which are covered by insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient will be repaid to Vitae Chiropractic Clinic.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated to Vitae Chiropractic Clinic, to perform such. I intend this consent form and financial agreement to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's Name (Please Print)

Date

Patient's Signature

Minor's Name (Please Print)

Date

Guardian's Signature