TRUEVINE CHIROPRACTIC

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Date: _____

Name:_____DOB /_____/_____Age:_____Male/Female

Address:_____City/State:_____Zip: _____

Phone: Home_____Cell_____Email: _____

Occupation:_____ Employer: _____

Marital Status: Single / Married / Divorced / Widowed Spouse's Name: _____

_____ Number of Children: Names, Ages, Gender_____

_____

_____

_____

Who can we thank for referring you here today? _____

Have you ever been to a Chiropractor before? Y / N

Please List Your Health Concerns Bellow:

Health Concerns: In Order of Importance	Severity 1=Mild 10=Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Is this constant or comes/goes?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____

How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?_____

_____

Main Complaint History:

1. How would you describe the pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

2. Does the pain travel anywhere else? ☐ Yes ☐ No Describe: _____

3. How often is this present?

☐ Constant (81 – 100%) ☐ Frequent (51 – 80%) ☐ Occasional (26 – 50%) ☐ Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____

5. What makes your complaint worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise (Moving) ☐ Lying Down ☐ Other

If other, please explain: _____

6. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who? _____

_____

7. Please list all medications you are taking and for what:

_____

8. Please list any broken bones, surgeries or hospitalizations you have had and when:

_____

9. Please list any auto accidents you have been involved in:

_____

10. Please CIRCLE any and all of these problems that you have had in the last 2 years:

Dizziness	Asthma	Kidney Problems	Chronic Fatigue
Headaches	Ulcers	Bladder Problems	Lupus
Vertigo	Chest Pain	Irritable Bowel	Fybromyalgia
Ear Infection	Arm Numbness	Sciatica	ADD/ADHD
Grating of Neck	Arm Pain	Leg Numbness	GERD
TMJ	Hand Numbness	Feet Numbness	Anxiety
Neck Pain	Shoulder Pain	Low Back Pain	Nervousness
Migraines	Heart Disorders	Hip Pain	Epilepsy
Stiffness in Neck	Mid Back Pain	Leg Pains	Disc Problems
Chronic Sinus	Stomach Disorders	Knee Pains	Infertility
Throat Issues	Nausea	Liver Disease	Other_____
Thyroid Issues	Reflux	Menstrual Issues	

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE SIGN BELOW

Name of Minor/Child: _____

I hereby authorize Dr. Kevin Kustarz and/or the staff of True Vine Chiropractic to perform a diagnostic evaluation, radiographic evaluation and/or chiropractic care and adjustments to my minor/child.

As of this date I have legal authority to select health care services for my minor/child. If at any point, this authority changes I will immediately notify True Vine Chiropractic.

Signed:_____ Relation to Minor/Child:_____

Team Witness:_____ 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 THE X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS IS $75.00. THIS FEE MUST BE PAID IN ADVANCE.

X-RAYS WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED N THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF TRUE VINE CHIROPRACTIC DO 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 YOUR NAME HERE	DATE
SIGNATURE	YOUR AGE

FEMALE PRACTICE MEMBERS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT TRUE VINE CHIROPRACTIC.

SIGNATURE	DATE

Terms of Acceptance

When a person seeks chiropractic and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 is by specific adjustments 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 alteration 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 a disease or condition other than vertebral subluxation. Regardless of what a 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 and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

I_____have read and fully understand the above statements.
(PRINT NAME)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

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 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and directy 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 contain 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 used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ _____
(Signature) (Date)

INFORMED CONSENT FOR CHIROPRACTIC CARE

I do hereby authorize the doctors of True Vine Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care. Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future give care to me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments for the sole purpose of postural and structural restoration to allow for normal motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I,_____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of care for my present condition and for any future conditions(s) for which I seek care.

_____
Print Practice Members Name

_____ _____
Signature (If minor / child, Guardian please sign) Date

_____
Relationship to minor / child

_____ _____
Witness Signature (Office Staff) Date