WELCOME

"Each patient carries his own doctor inside him. We are at our best when we give the doctor who resides within each patient a chance to work." – Albert Schwietzer, MD.

Contact Info

last name	first name	date of birth
street		
city	state	zip code
parent/guardian last name	first name	relationship
home phone	mobile phone	
work phone	email	

Health History

Purpose For Contacting Us?_____

Other Doctors Seen for this Condition: Y N Doctors' Names and Treatments:_____

_____

_____

Other Health Problems?_____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear infections ☐ Scoliosis ☐ Seizures ☐ Growing/Back pains ☐ Headaches
☐ Digestive problems ☐ ADHD ☐ Recurring fevers ☐ Chronic colds ☐ Asthma/Allergies
☐ Bed wetting ☐ Colic ☐ Car accident ☐ Temper tantrums

Other_____

History

Family history:_____

Previous chiropractor:_____

Date of last visit: ___/___/___ Reason:_____

Name of pediatrician:_____

Date of last visit: ___/___/___ Reason:_____

Are you satisfied with the care your child receives there? Y N

Number of doses of antibiotics your child has taken: During the past six months:_____ Lifetime:_____

List the antibiotics taken:_____

Vaccination history:_____

Prenatal History

Name of Obstetrician/Midwife:_____

Complications during pregnancy? Y N ,_____

Ultrasounds during pregnancy? Y N , Number:_____

Medications during pregnancy/delivery? Y N ,List:_____

Cigarette/Alcohol use during pregnancy? Y N

Location of birth: ☐ Hospital ☐ Birthing center ☐ Home

Birth intervention: ☐ Forceps ☐ Vacuum extraction ☐ Caesarian section- ☐ Emergency or ☐ Planned

Complications during delivery? Y N ,List:_____

Genetic disorders or disabilities: Y N ,List:_____

Birth weight:_____ Birth length:_____ APGAR Scores:_____,_____

Feeding Hx

Breast fed: Y N , How long:_____
Formula fed: Y N , How long: _____ Type:_____
Introduced to solid foods at:_____ Months, Cows milk at _____Months
Food/Juice allergies or intolerances: Y N ,List_____
_____

Developmental Hx

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to :

_____ Respond to stimuli(sounds and touching) _____ Respond to visual stimuli _____ Hold head up
_____ Sit up _____ Cross crawl _____ Stand Alone _____ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.)

Was this the case with your child? Y N
Is / Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, Martial arts, etc.)? Y N ,List:_____
Has your child ever been in a car accident? Y N ,List:_____
Has your child been seen on an emergency basis? Y N ,List:_____
Other traumas not described above? Y N ,List:_____
Prior surgery? Y N ,List:_____

Childhood diseases:

Chicken Pox Y N , Age:_____ Rubella Y N , Age:_____ Rubella Y N , Age:_____
Mumps Y N , Age:_____ Whooping Cough Y N , Age:_____ Other Y N , Age:_____

Do Not Write Below This Line

Infant Physical Exam

Supine Leg Length Check ____

Infant Reflexes – Under 1	Right	Left
Rooting	P A	P A
Sucking	P A	P A
Nasopalperbral	P A	P A
Blink	P A	P A
Pupillary	P A	P A
Head control	P A	P A
Tonic neck	P A	P A
Neck righting	P A	P A
Otolith righting	P A	P A
Palmar grasp	P A	P A

P – present A – absent

Palpation Exam

OCC	C1	C2	C3	C4	C5	C6	C7	
T1	T2	T3	T4	T5	T6	T7	T8	T9
T10	T11	T12		L1	L2	L3	L4	L5
SAC	LI	RI	Doctor's Notes:					

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:_____

SOCIAL MEDIA AND MARKETING RELEASE

We love to have pictures, videos, and testimonials in our office! If you would allow us to have your picture/video in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by True Vine Chiropractic, or anyone authorized by True Vine Chiropractic, of any and all photographs/videos which were taken of myself and my child(ren), for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of True Vine Chiropractic, solely and completely. Any information voluntarily provided by a practice member shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize True Vine Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated practice member information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature _____ Date _____

TRUE VINE CHIROPRACTIC

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

PLEASE NOTE: X-RAYS ARE UTILIZED IN 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 _____

TRUEVINE CHIROPRACTIC

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 directly 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)

TRUE VINE CHIROPRACTIC

Communication Consent

When you provide us with your contact information, we may use that information to provide you services. For example, we may use your contact information to send you appointment reminders and office updates via text or SMS message. We may use business partners to provide these services to you. If you do not wish for us to share that information with any third parties, please notify us. But recognize that if you choose not to share the information, we may not be able to provide you with certain services.

_____ _____

(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.

_____ _____

Signature of Practice Member or Guardian (for minor/child) Date

_____

Relationship to minor / child

_____ _____

Witness Signature (Office Staff) Date