VITAL ROOTS
CHIROPRACTIC

Patient Name: _____ **Nickname:**_____ **DOB:** _____

Gender: _____ **Referred By:** _____ **Last Chiropractic Adjustment:** _____

Address:_____

Email: _____ **Phone:** _____

Emergency Contact: _____**Phone:**_____ **Occupation:** _____

HISTORY OF COMPLAINT:
List the condition(s) that brought you in today. The pain scale is 0-10, 0 is no pain and 10 is the worst

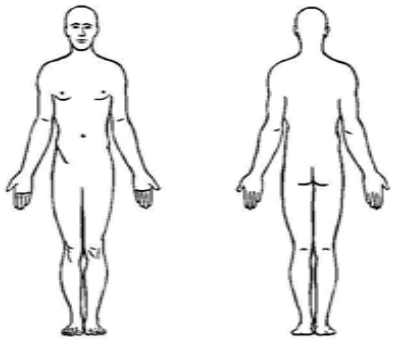
Primary complaint: _____ **Level of pain:** _____ **Start date:** _____

Second: _____**Level of pain:** _____ **Start date:** _____

Third: _____ **Level of pain:** _____ **Start date:** _____

When is it the worst? Morning Afternoon Night Overnight Is it: Constant On/Off Daily Sporadic During Week

Mark the areas on the diagram with a LETTER to describe your symptoms
R: Radiating B: Burning D: Dull
A: Aching N: Numbness T: Tingling
S: Sharp/stabbing



What relieves your symptoms? _____

What makes it worse? _____

How did the injury happen? _____

Is this a result of an ANY type of accident? YES NO

Have you been treated for this in the past? YES NO If yes, what type?
_____

SOCIAL HISTORY:
Smoking: ____**Cigars** _____**Pipes** _____**Cigarettes How often?** ____ **Daily** ____ **Weekends** ____ **Occasionally** ____**Never** _____ **Quit**

Alcohol: Drinks per day? _____ **Consumption:** _____ **Daily** _____ **Weekends** _____ **Occasionally** _____**Never** _____ **Quit**

Recreational Drug Use: Name _____ _____ **Daily** _____ **Weekends** _____ **Occasionally** _____**Never** _____ **Quit**

Medications you take (incl vitamins and supplements)
_____
_____
_____

Initials _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with: (indicate P for Past, C for Currently have and N for Never had)

	Headache		Pregnant (Now)		Dizziness		Prostate Problems		Ulcers
	Neck Pain		Frequent Colds / Flu		Loss of Balance		Impotence/Sexual Dysf		Heartburn
	Jaw Pain / TMJ		Convulsions / Epilepsy		Fainting		Digestive Problems		Heart Problems
	Shoulder Pain		Tremors		Double Vision		Colon Trouble		High Blood Pressure
	Upper Back Pain		Chest Pain		Blurred Vision		Diarrhea/Constipation		Low Blood Pressure
	Mid Back Pain		Pain with Cough / Sneeze		Ringing in Ears		Menopausal Problems		Asthma
	Low Back Pain		Foot / Knee Problems		Hearing Loss		Menstrual Problems		Difficulty Breathing
	Hip Pain		Sinus / Drainage Problem		Depression		PMS		Lung Problems
	Back Curvature		Swollen / Painful Joints		Irritability		Bed Wetting		Kidney Trouble
	Scoliosis		Skin Problems		Mood Changes		Learning Disability		Gall Bladder Trouble
	Numb / Tingling Arms, Hands, Fingers				ADD/ ADHD		Eating Disorder		Liver Trouble
	Numb / Tingling Legs, Feet, Toes				Allergies		Trouble Sleeping		Hepatitis (A, B, C)

	Broken Bone		Dislocations		Tumors		Rheumatoid Arthritis		Fracture		Disability
	Heart Attack		Osteoarthritis		Diabetes		Cerebral Vascular Dis		Cancer		Other

	TYPE	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES				
SURGERIES				
DISEASES				

FAMILY HISTORY:

List any relevant conditions to your own. If you need more room, please check here _____ and use the back of this page.

Relationship (ex:Mom, Dad, Sibling)	Condition	Did they get treatment? (Ye,s No, Not Sure)

Initials _____

Please Identify how your current condition is affecting your ability to carry out routine activities

Activity	No Effect	Painful (can do)	Painful (limits)	Unable to do	Activity	No Effect	Painful (can do)	Painful (limits)	Unable to do
Carry Children / Groceries					Sit to Stand				
Lift Children / Groceries					Climb Stairs				
Extended Computer Use					Pet Care				
Read / Concentrate					Getting Dressed				
Sexual Activities					Shaving				
Static Sitting					Sleeping				
Static Standing					Yard Work				
Washing /Bathing					Walking				
Sweeping / Vacuuming					Dishes				
Garbage					Laundry				
Driving					Other: _____				

I certify that the above information given is true and accurate. I will inform Vital Roots Chiropractic, PLLC of any changes.

Patient Name _____ **Signature** _____ **Date** _____

Initials _____

Consent For Care:

Patient Name _____DOB: _____

HIPAA Acknowledgement: I give Vital Roots Chiropractic, PLLC permission to speak with the following people in regard to my care, appointments, insurance, billing, test results, claims etc.

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

I acknowledge that the HIPAA policy is posted in the office and that I have read it. I understand that I can ask for a copy at any time.

Consent to Treat: I give my consent to Vital Roots Chiropractic, PLLC to perform any and all examinations, tests, treatment, physical therapy and other reasonable measures it deems necessary to diagnose and treat my condition.

My signature affirms I understand and do not have any questions on all of the statements made above.

Text/ Email/ Social Media:

____ (Initials) I give Vital Roots Chiropractic, PLLC permission to text and/or email me for the purpose of appointment reminders and special events. Special messages, events or promotions will be emailed and limited to 2 (two) per month.

____ (Initials) I give Vital Roots Chiropractic, PLLC permission to take pictures and/or videos for the purpose of marketing and social media.

Print: _____ Signature:_____ Date: _____

Reviewed by: **Vital Roots Chiropractic, PLLC** ***Dr. Cassandra Almeida, D.C.*** **Date: _____** **Signature:** _____	**Notes:**

Initials _____

Terms of Acceptance

Patient Name _____DOB: _____

Terms of Acceptance: You are the decision maker for your health care. Part of our role is to provide you with information to empower you to make informed choices. The 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: muscles spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs, and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot with the potential to lead to a stroke). The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease process, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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 it 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 recommendations 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.

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Print: _____ Signature:_____ Date: _____

Initials _____