**Thank you for choosing**

**Vibrant Life Chiropractic**

**Please take a few minutes to tell me a little bit about yourself and how I may help you. If you are unsure how to answer or have any questions please feel free to ask. Please print clearly.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_­\_\_/\_\_\_\_/\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_ #of Children \_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who may I thank for referring you to the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you seen a Chiropractor before? Y/N If yes, date of your last spinal checkup? \_\_­­­\_\_\_\_\_\_\_

**Addressing The Issues That Brought You To This Office…**

Although I do not treat any specific symptom or condition, I do realize that symptoms and conditions may arise as a result of nerve interference/subluxation.

If you have no symptoms or complaints please check here \_\_\_\_\_ “**I wish to have chiropractic wellness care**” and skip to the Other Symptoms section.

Otherwise briefly describe the chief area of complaint, including the effect it has had on your life. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Problem started on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Since the issue started, it is: \_\_\_\_The Same \_\_\_\_Better \_\_\_\_Worse If experiencing pain, please describe: \_\_\_Sharp \_\_\_Achy \_\_\_Dull \_\_\_Constant \_\_\_Comes/goes \_\_\_Radiating Are you experiencing any: \_\_\_\_numbness \_\_\_\_tingling \_\_\_\_extremity weakness \_\_\_\_lack of coordination What makes the condition better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the condition worse during certain times of the day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this condition interfering with: Work?\_\_\_\_ Sleep?\_\_\_\_ Exercise?\_\_\_\_ Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you seen other doctors for this condition? If yes, when? Diagnosis given? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_­­­­­­­­­ Have you had X-rays, MRIs or other testing? If so what were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other Symptoms:** (you are currently experiencing or have a history of)

* Headaches
* Neck pain
* Back Pain
* Sleeping Problems
* Nervousness
* Tension
* Irritability
* Chest Pains
* Dizziness
* Hot Flashes
* Stiff Neck
* Pins/Needles - Arms
* Pins/Needles - Legs
* Numbness in Fingers
* Numbness in Toes
* Shortness of Breath
* Fatigue
* Depression
* Anxiety
* Light Sensitivity
* Loss of Memory
* Ringing in Ears
* Changes in Vision
* Fever
* Fainting
* Cold Sweats
* Loss of Smell/Taste
* Menstrual Pain
* Irreg. Period
* Diarrhea
* Cold Feet
* Cold Hands
* Upset Stomach
* Vomiting
* Constipation
* Ulcers
* Unexplain. Wt. Loss
* Unexplain. Wt. Gain
* Loss of Balance
* Loss of Appetite

What medications are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you experiencing any med side effects? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosed Diseases or Conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle Habits** Do you exercise regularly? **Y / N** How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you stretch daily? **Y / N** Do you meditate? **Y / N** Are you a smoker? **Y / N** Have you recently quit smoking? **Y / N** When? \_\_\_\_\_\_\_\_ Do you notice changes in your health since quitting? **Y / N** Do you take vitamins/supplements/herbal remedies to improve health? **Y / N** Are you a positive or negative thinker? **+ / -**

**Wellness Commitment:**

As a chiropractor I am fully dedicated to achieving the goal of optimizing the inborn potential of all of my practice members. To better help you achieve this goal I need to understand **your commitment** to being your best. Based on a scale of 0% to 100%, please circle your personal level of commitment to enhancing your human potential and overall health and wellness.

**0%---------10%---------20%---------30%---------40%---------50%---------60%--------70%---------80%---------90%---------100%**

As a result of my chiropractic care, I would like to: **Please Check All That Apply:**

* Feel Better
* Optimize my overall function and performance
* Be able to better adapt to stress (physical, chemical, emotional)
* Enhance my expression of health, life and my genetic potential

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**Acceptance of Office Policies**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have received, read and understand the office policies of VLC. All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ Signature Printed Name Date

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Drs.Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Welcome to Vibrant Life Chiropractic!**

Before beginning the intake form please take a few moments to read about my objectives and goals in providing you and your family with chiropractic care. If after reading my statement below you share in my philosophy of health and wellness and would like to explore the benefits of chiropractic care for you and your family please sign below and continue on to the next page.

When a person seeks chiropractic care and when a chiropractor accepts a person for such care, it is essential that they both be seeking and working for the same goals.

In all truth, chiropractic has only one goal; the detection and correction of vertebral subluxation for the removal of interference of the nerve system. This in turn improves the overall function of the body allowing you to heal better, which ultimately leads to you feeling better. It is therefore important that each person understands the goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding or disappointment.

**Folks usually want to get rid of whatever ailments or conditions are bothering them. But please remember that the chiropractor does not have a magic adjustment to cure, heal or treat your condition. The chiropractor’s goal is to improve the function of the body, which in turn improves your healing ability; when you heal better you will eventually feel better.**

**The purpose of chiropractic is to restore and maintain the health of the spine and its relationship between the spinal cord and nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignment of the vertebrae, or bones of the spine, which interfere with the function of these nerve pathways are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.**

**By means of a chiropractic adjustment subluxations are corrected, thus the normal nerve function restores itself. The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing proper transmission of nerve energy over nerve pathways so that every part of your body may have a proper nerve supply at all times.**

**This allows the innate (inborn, natural) healing ability of the body to work at maximum efficiency allowing you to express your innate potential to the best of the body’s ability. When the body is functioning free of interference you heal better and ultimately you feel better.**

Regardless of what the disease is called the chiropractor DOES NOT offer to heal or even treat it, nor does she offer advice regarding the treatment of disease. The only goal is to allow the body to do its job. The only means is to adjustment of the vertebral subluxations. There are no promises to cure and no offers of the treatment of disease.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the above and fully understand and choose to receive chiropractic care for myself and/or family members on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ Initials Date

**Vibrant Life Chiropractic**

***Informed Consent to Chiropractic Care***

**The nature of chiropractic care:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as soft tissue work, hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce bruising, skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic care have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options which could be considered** may include the following:

* *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
* *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
* *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
* *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of care will complicate the condition and make future rehabilitation more difficult.

**I have read the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing care. I have freely decided to undergo the recommended care, and herby give my full consent.**

**Consent for a minor:**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ accept care on behalf of my minor son/daughter.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Printed Name Signature Date**