# VIDA chiropractic studio

4650 West 38TH Avenue #210 Denver, CO 80212 303.433.5433

Name:______________________________________________Date:______________

Address: :___________________________________City:_________State:_____Zip:__________

Cell Ph:________________Carrier:_________Home Ph:____________Work Ph:____________

Best number to contact you: Home Work Cell Social Security #__________________________

Email Address:________________________________________________________________

Birth Date:___________Age:______ Sex: M F Circle: single married partnered widowed divorced separated

Occupation:__________________ Employer:________________ # of hours worked per week:_____

Significant Other's Name:____________________Significant Other's Occupation:________________

Names and Ages of Kids:______________________________________________________

**Who can we thank for referring you to VIDA?**_________________________________________

Main reason for consulting our office today: ___________________________________________

Any information about your Nerve System and Spine we should know:__________________________

What is your level of commitment to yourself, your life and well-being? ___High ___Medium ___Low

Have you ever sought the services for this or any other health concern from the following:

___Massage Therapist ___Acupuncturist ___Naturopath ___Yoga Studio ___Physical Therapist
___Personal Trainer ___Nutritionist ___Rolfer ___Pilates ___Other__________
___Chiropractor

Have you ever been adjusted by a chiropractor before? ___Yes ___No

Office:_____________________________ Date of last adjustment:_________________________

Frequency of care: ___________x per week/month Duration of care:_________weeks/months/years

What is your daily fluid intake: Coffee____/week Alchohol____/week Water____/day Soda____/week

Sleep/Rest Habits: Daytime naps: Y N Hours a night:____/hrs Do you wake up refreshed? Y N

What type of work do you do?___________________________________Satisfied/Enjoy your work? Y N

Exercise Habits:(please describe what you do and how often)

What are your current play and relaxation activities?

Do you use prescription, over the counter and/or recreational drugs/medications? Y N (if yes, please list)

If you are presently taking any medication or vitamins, please list their names and purpose:

| | Name | Purpose |
|---|---|---|
| 1. | ____________ | ____________ |
| 2. | ____________ | ____________ |
| 3. | ____________ | ____________ |
| 4. | ____________ | ____________ |

Are you pregnant? Y N # of weeks:__________

**Check any of the symptoms or conditions below that you have experienced in the last 6 months?**

| | | | |
|---|---|---|---|
| __Headache | __Pins/needles in arms/hands | __Dizziness | __Menstrual irregularity |
| __Neck Pain | __Pins & needles in legs/feet | __Vertigo | __Menstrual cramps |
| __Mid-Back Pain | __Pains in legs & feet | __Carpal Tunnel | __Hot Flashes |
| __Low back pain | __Numbness in Arms/Legs | __Shoulder/Arm Pain | __Scoliosis |
| __Leg or Hip Pain | __Pain b/w Shoulder Blades | __Digestive Problems | __Aids/HIV |
| __Sciatic Pain | __Allergies | __TMJ | __Sleeping problems |
| __Migraines | __Fainting | __Heart attacks | __Infertility |
| __Shooting head pains | __Loss of balance | __High blood pressure | __Sexual dysfunction |
| __Sinus trouble | __Ringing in ears | __Chronic colds/flu | __Constipation |
| __Head feels too heavy | __Seizures | __Nervous stomach | __Diarrhea |
| __Muscle spasms in neck | __Lights bother eyes | __Ulcers | __Urinary dysfunction |
| __Asthma | __Heart palpitation | __Depression | __Bowel dysfunction |
| __Indigestion | __Shortness of Breath | __Inner tension | __Painful/swollen joints |
| __Tightness of throat | __Tension across top of shoulders | __Irritability | __Slipped disc |
| __Throat inflammation | | __Fibromyalgia | __Pinched nerves in back |
| __Ear aches | ___Intestinal gas | __Low Energy/Fatigue | |

__Cancer, type________________________________

__ Other________________________________

**Which one of the above sytptoms is worst?**____________________ **How long have you had it?**________

**When it as at its worst, how does it feel**________________________________

**The following three areas can contribute to nerve interference and diminished quality of life. Circle the areas that apply to you and when.**

**C = child T = teenagers A = adult N=not al all (circle one in each category)**

| **Physical Stress** | | **Emotional Stress** | | **Chemical Stress** | |
|---|---|---|---|---|---|
| Birth Traumas | C T A N | Relationships | C T A N | Environmental | C T A N |
| Slips/Falls | C T A N | Career | C T A N | Smoker | C T A N |
| Car Accidents | C T A N | Family | C T A N | Second Hand Smoke | C T A N |
| Sports Injuries | C T A N | Money | C T A N | Poor Diet | C T A N |
| Physical Abuse | C T A N | Fast Paced Life | C T A N | Caffeine | C T A N |
| Work Injuries | C T A N | Hold in Feelings | C T A N | Prescription Drugs | C T A N |
| Poor Posture | C T A N | Quick Tempered | C T A N | Self Medicate | C T A N |
| Sitting on our wallet | C T A N | Perfectionist | C T A N | Recreational Drugs | C T A N |
| Stomach Sleeper | C T A N | Procrastinator | C T A N | | |
| Computer Work | C T A N | Loss of loved One | C T A N | | |
| Repetitive Lift/Bending | C T A N | | | | |
| Driving for Many Hours | C T A N | | | | |
| Continuous Standing | C T A N | | | | |
| Continuous Sitting | C T A N | | | | |
| Bone fracture/Surgery | C T A N | | | | |
| Lack of Physical Activity | C T A N | | | | |
| Excess of Physical Activity | C T A N | | | | |

- What do you feel is the primary stressor in your life?
- Rate (circle) your combined overall level of stress from all sources listed above
  No Stress—1—2—3—4—5—6—7—8—9—10—High Stress

***How we protect your Health Information:***

## PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HEALTHCARE PURPOSES

By signing this Consent, I acknowledge and provide permission to VIDA Chiropractic Studio (Practice) as follows:

1. The Studio's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and disclosures of my protected health information ("PHI") necessary for the Practice to provide care to me, and also necessary for the Practice to obtain payment for that care and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and /or disclose my PHI (which includes information about my health or condition and the care provided to me) in order for the Practice to care for me and obtain payment for that care, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out care, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, that the restriction is binding on the Practice.

6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice reserves the right to not care for me.

**I have read and understand the health information disclosure and protection in the foregoing notice,**

______________________________ ______________________________

PRINTED Name SIGNATURE

______________________________

DATE

______________________________ ______________________________

Signature of Legal Guardian (e.g. if a minor) Relationship to minor