

VITALITY CHIROPRACTIC FAMILY WELLNESS CARE

4080 Loma Vista Road, Ste. H., Ventura, CA, 93003 • (805) 648-6866 • VITALITYCHIROPRACTIC@GMAIL.COM

Dr. Sharon MacDonald, D.C.

Health Profile

Welcome! Thank you for choosing chiropractic and for trusting our office to address your health and wellness needs. Please take the time to answer the following questions completely. Your answers will help us better understand your health concerns.

Patient Information

Name _____
Address _____
City _____
State _____ Zip _____
Email _____
Sex Male Female Age _____
Birth date _____
Do you have children? Yes No
What are their names? _____

Today's date _____
Occupation _____
Employer / School _____
Employer / School Address _____
Employer / School Phone _____
Spouse / Partner's Name _____
Spouse / Partner's Employer _____
Spouse / Partner's Birth date _____
Who can we thank for referring you? _____

Phone Numbers

Home (____) _____ Cell (____) _____
Best time / place to reach you _____

Emergency Contact

Name _____ Relationship _____
Home (____) _____ Work (____) _____

Accident Information

Is this condition due to an accident? Yes No
Type of accident Auto Work Home Other
To whom have you made a report of your accident?
 Auto Insurance Employer Other _____
Attorney Name (If Applicable) _____

Patient Condition

If you have no symptoms or complaints and are here for wellness care, please circle **YES**

Reason for this Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.

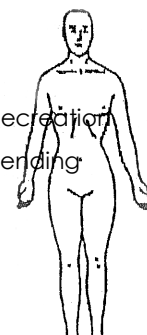
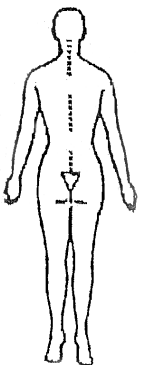
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Cramps Tingling Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation
Activities that are painful to perform: Sitting Standing Walking Bending Lying Down



Health History

Have you seen another doctor regarding this condition? Yes No If "Yes", what was the diagnosis? _____

Name of other doctor(s) / therapist(s) who have treated you for your condition? _____

What treatment have you already received for your condition? Chiropractic Physical Therapy Acupuncture
 Massage Medication Surgery None Explain / Other _____

Date of Last: Physical Exam _____ Dental Visit _____ Dental X-Ray _____

Spinal Exam _____ Spinal X-Ray _____ Chest X-Ray _____

MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Please circle any of the following conditions you have / are experiencing.

AIDS/HIV	Colitis / IBS	Heart Disease	Parkinson's Disease
Allergies _____	Constipation	Hepatitis	Polio
Anemia	Depression	Hernia	Prostate Problems
Appendicitis	Diabetes	Herniated Disk (level) ____	Rheumatoid Arthritis
Arthritis	Dizziness	Herpes	Ringing in Ears
Artificial Bones/Joints	Ear Aches	High Cholesterol	Stenosis in Neck in Low Back
Asthma	Emphysema	High/Low Blood Pressure	Stroke
Auto-Immune Disease	Epilepsy/Seizures	Kidney Disease	Thyroid Problems
Bleeding Disorders	Fainting	Liver Disease	Tonsillitis
Blurred Vision	Fatigue	Measles	Tuberculosis
Breast Lump	Fracture	Menstrual Pain / Irreg.	Tumors / Growths
Breathing Difficulties	Fever	Miscarriage	Ulcers
Bronchitis	Gas/Bloating	Migraine Headaches	Vaginal Infections
Bladder/Bowel Changes	Glaucoma	Multiple Sclerosis	Weight Loss / Gain _____ lbs
Cancer (Type) _____	Goiter	Mumps	Other / Explain _____
Chest Pain	Gout	Osteoporosis	_____
Chicken Pox / Shingles	Headaches	Pacemaker	_____

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Are you pregnant? Yes No Due Date _____

Are you nursing? Yes No

Injuries / Surgeries

Description

Date

Falls	_____	_____
Head Injuries	_____	_____
Accidents (Auto / Sports / Other)	_____	_____
Dislocations / Fractures / Broken Bones	_____	_____
Surgeries	_____	_____
Other	_____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

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Informed Consent and Authorization for Chiropractic Care

I have reviewed the above Health Profile and have completed it accurately and to the best of my knowledge. I understand that this information will be used to assess my condition (or the patient named below for whom I am legally responsible) and determine the most appropriate course of care. If there is any change in my condition or my medical status generally, I will inform the doctor so that she may alter my care plan as needed.

I (or the patient named below for whom I am legally responsible) request and consent to undergo care as recommended by the doctor including the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapy, exercise prescription and diagnostic x-rays, by the doctor of chiropractic named above and / or licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for, the doctor of chiropractic above, including those working at the clinic or office listed or any other office of clinic.

I have been advised of the associated risks / benefits of undergoing care as well as other treatment options which I may pursue exclusively or in conjunction with my care in this office. I understand and am informed that as in the practice of other health professions, in the practice of chiropractic there are some risks to treatment, including but not limited to, strain, sprain, fractures, disc injuries, strokes, and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment, based on the facts known, during the course of the treatment.

I understand that the information provided herein is strictly confidential and that my written authorization will be required in order for any of my information to be released.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the enter course of treatment for my present condition and for any future conditions for which I seek treatment in this office.

To Be Completed By Patient:

Print Patient's Name

Patient Signature

Date

To Be Completed By Patient's Representative or If Minor, By Parent or Guardian

Print Name of Patient

Print Name of Patient's Parent / Guardian or Representative

Signature of Patient's Parent / Guardian or Representative

Relationship to / or Authority of Patient's Representative

Date

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Office Policy

We have an open communication policy in this office. To avoid any misunderstandings between the patient and the office, we appreciate you taking a moment to review the following information. We welcome any questions you may have regarding this information or your care in general.

Cash Patients

It is customary that you pay for each visit as you go. X-rays must be paid for on the day that they are taken. For those cash patients who would like to establish a prepaid plan, please ask for more information. For those cash patients who are unable to pay according to the schedule already mentioned we will gladly set up a payment plan for you.

Insurance Patients

Please have your insurance card ready and a form of picture identification so we can make a copy of it for your file. Once we have confirmed that your health insurance covers chiropractic care, we will be happy to bill your insurance company. Most of the insurance companies pay between 60 to 80%. The remainder then becomes your responsibility and will be billed to you directly. Remember, you the patient, are ultimately responsible for the bill. We will be happy to help you with any insurance problems or questions that may arise.

All Patients

Every appointment represents a specific amount of time reserved for you and your family. Should you fail to keep your appointment without properly notifying our office 24 hours in advance, a minimum fee of \$50.00 will be posted to your account.

Your care is of the utmost importance to us. If you have a financial problem, please let us know ahead of time. We will work with you to arrange a payment plan that is both manageable and agreeable to you.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named office policies

Print Patient's Name

Print Name of Patient's Parent / Guardian or Representative

Patient Signature

Signature of Patient's Parent / Guardian or Representative

Date

Relationship to Patient