

1484 E. Main Street, Ventura, CA, 93001 ☐ (805) 648-6866 ☐  
VITALITYCHIROPRACTIC@GMAIL.COM

Sharon A. 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

Today's date \_\_\_\_\_ Occupation \_\_\_\_\_  
Name \_\_\_\_\_ Employer/School \_\_\_\_\_  
Address \_\_\_\_\_ Employer/School Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
E-mail \_\_\_\_\_ Spouse / Partner's Name \_\_\_\_\_  
Sex  Male  Female Age \_\_\_\_\_ Spouse / Partner's Birthdate \_\_\_\_\_  
Married  Widowed  Single  Minor Do you have children?  Yes  No  
Divorced  Partnered for \_\_\_\_\_ years What are their names? \_\_\_\_\_  
Birthdate \_\_\_\_\_ Spouse / Partner's Employer \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

### Phone Numbers

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Best time / place to reach you \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

### 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) \_\_\_\_\_

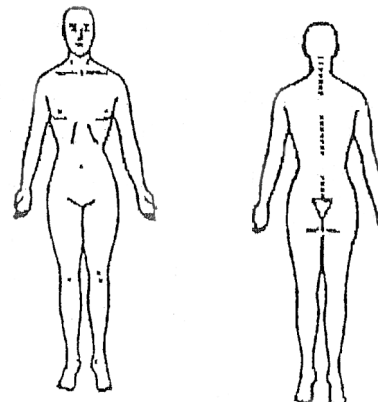
Type of Pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting

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



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

Name and address 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  Medication  Acupuncture

Massage  Surgery  None Explain / Other \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Dental Visit \_\_\_\_\_ Dental X-Ray \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Chest X-Ray \_\_\_\_\_

Blood Test \_\_\_\_\_ Urine Test \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Circle Y (for Yes) or N (for No) to indicate if you have had any of the following. Circle C if this condition is current.

AIDS/HIV Y N C Colitis / IBS Y N C Heart Disease Y N C Parkinson's Disease Y N C

Allergies Y N C Constipation Y N C Hepatitis Y N C Polio

N C

Anemia Y N C Depression Y N C Hernia Y N C Prostate Problems Y N C

Appendicitis Y N C Diabetes Y N C Herniated Disk (level) Y N C Rheumatoid Arthritis Y N C

Athritis Y N C Dizziness Y N C Herpes Y N C Ringing in Ears

N C

Artificial Bones/Joints Y N C Ear Aches Y N C High Cholesterol Y N C Stroke Y N C

Asthma Y N C Emphysema Y N C High/Low Blood Pressure Y N C Thyroid Problems Y N C

Auto-Immune Disease Y N C Epilepsy/Seizures Y N C Kidney Disease Y N C Tonsillitis Y N C

Eating Disorders Y N C Fainting Y N C Liver Disease Y N C Tuberculosis Y N C

Blurred Vision Y N C Fatigue Y N C Measles Y N C Tumors / Growths Y N C

Breast Lump Y N C Fracture Y N C Menstrual Pain / Irreg. Y N C Ulcers Y N C

Breathing Difficulties Y N C Fever Y N C Miscarriage Y N C Vaginal Infections Y N C

Bronchitis Y N C Gas/Bloating Y N C Migraine Headaches Y N C Weight Loss Y N C

Bowel/Bladder Changes Y N C Glaucoma Y N C Multiple Sclerosis Y N C Other / Explain \_\_\_\_\_

Cancer (Type) Y N C Goiter Y N C Mumps Y N C \_\_\_\_\_

Joint Pain Y N C Gout Y N C Osteoporosis Y N C \_\_\_\_\_

Chicken Pox / Shingles Y N C Headaches Y N C Pacemaker Y N C \_\_\_\_\_

**Exercise**

**Work Activity**

**Habits**

None  Sitting  Smoking  Packs/Day \_\_\_\_\_

Moderate  Standing  Alcohol  Drinks/Week \_\_\_\_\_

Daily  Light Labor  Coffee/Caffeine Drinks  Cups/Day \_\_\_\_\_

Heavy  Heavy Labor  High Stress Level  Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_ Are you nursing?  Yes  No

**Injuries / Surgeries**

**Description**

**Date**

Ills \_\_\_\_\_

Head Injuries \_\_\_\_\_

Accidents (Auto / Sports / Other) \_\_\_\_\_

Dislocations / Fractures / Broken Bones \_\_\_\_\_

Surgeries \_\_\_\_\_

Other \_\_\_\_\_

**Medications**

**Allergies**

**Vitamins/Herbs/Minerals**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# VITALITY CHIROPRACTIC FAMILY WELLNESS CARE

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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 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; 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, dislocations, strokes, and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications. I will 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 / signing below I agree to the above named procedures. I intend this consent form to cover the entire 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:

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

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Name of Patient's Parent / Guardian or Representative

\_\_\_\_\_  
Signature of Patient's Parent / Guardian or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to / or Authority of Patient's Representative

\_\_\_\_\_  
Date

VITALITY CHIROPRACTIC FAMILY WELLNESS CARE

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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.

### Ill 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 work with you to arrange a payment plan that is both manageable and agreeable to you.

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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 Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian  
Signature \_\_\_\_\_