

NEW PRACTICE MEMBER APPLICATION



T C A

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

For future appointment confirmation do you prefer:  Text  Email  Phone Call **Cell Phone Provider:** \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No **Insurance Provider:** \_\_\_\_\_

**Do you make your own financial decisions?**  Yes  No

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Number of children and Ages: \_\_\_\_\_

**Whom may we thank for referring you to this office** → \_\_\_\_\_?

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_

Secondarily: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

- **Primary** or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  Constant  Intermittent
- **Second** complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  Constant  Intermittent
- **Third** complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  Constant  Intermittent
- **Fourth** complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  Constant  Intermittent

**When did the problem(s) begin?** \_\_\_\_\_ **When is the problem at its worst?**  AM  PM  mid-day  late PM

**How did the injury happen?** \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes; **if yes**, when: \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

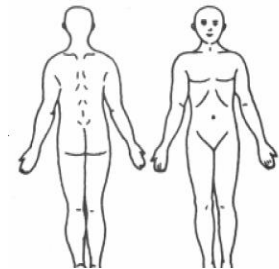
Name of Previous Chiropractor: \_\_\_\_\_  N/A

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:  
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes  No



PAST HISTORY

Have you suffered with any of this or a similar problem in the past?  No  Yes **If Yes** how many times? \_\_\_\_\_

When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **if yes**, please state **what** type of treatment: \_\_\_\_\_, and **who** provided it: \_\_\_\_\_ **How long ago?** \_\_\_\_\_ What were the results:  Favorable  Unfavorable

Please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_

Mark any of the following if you have ever been diagnosed or currently have any of the listed conditions:

- \_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer
- \_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

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

**SOCIAL HISTORY**

1. **Smoking:**  cigars  pipe  cigarettes → How often do you smoke?  Daily  Weekends  Occasionally  Never
2. **Alcoholic Beverage:** consumption occurs →  Daily  Weekends  Occasionally  Never
3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never
4. **Hobbies -Recreational Activities- Exercise Regime:**  Daily  Weekends  Occasionally  Never

How does your present problem affect the following? \_\_\_\_\_

**FAMILY HISTORY:**

1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
 If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
 Have they ever been treated for their condition?  No  Yes  I don't know
2. Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_

**Please mark any and all of the problems you currently have or have had in the last 6 months:**

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision    | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision   | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears  | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss     | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Depression       | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable        | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes     | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Eating Disorder  | <input type="checkbox"/> Liver Trouble            |   |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C)        |   |

I hereby authorize payment to be made directly to [Vitalife Chiropractic](#), for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Vitalife Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Form Reviewed**



## FAMILY HEALTH HISTORY

The reason for this form is to assist the doctor by providing relevant family history information for their review.

Condition	Self	Spouse	Son	Daughter	Mother	Father	Grandchildren
Arm Pain							
Arthritis							
Asthma							
Attention Deficit							
Back Trouble							
Bed Wetting							
Cancer							
Carpal Tunnel							
Deceased							
Diabetes							
Digestive Problems							
Disc Problems							
Ear Infections							
Ears/Nose/Throat							
Fibromyalgia							
Headaches							
Heart Trouble							
High Blood Pressure							
Hip Pain							
Immune Disorder							
Leg Pain							
Migraines							
Neck Pain							
Nervousness							
Pinched Nerve							
Currently Pregnant							
Scoliosis							
Seizures							
Shoulder Pain							
Sinus Trouble							
Sports Activities							
TMJ							
Hemophilia							
Osteoporosis							
Thyroid Disorders							

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

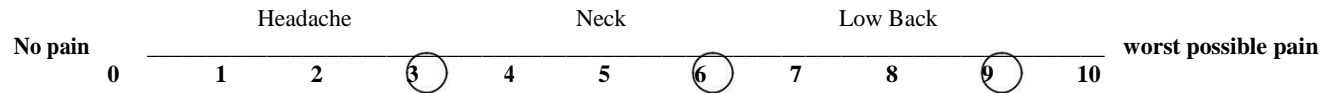
Date \_\_\_\_\_

**Please read carefully:**

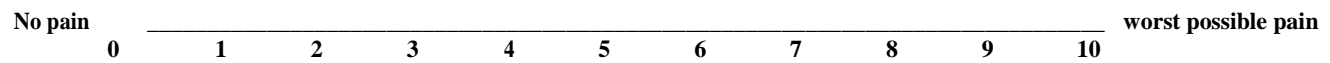
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

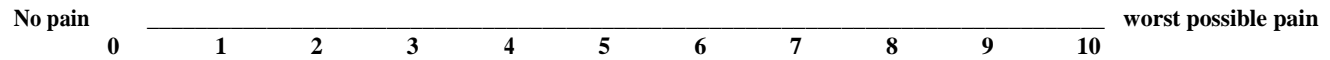
**Example:**



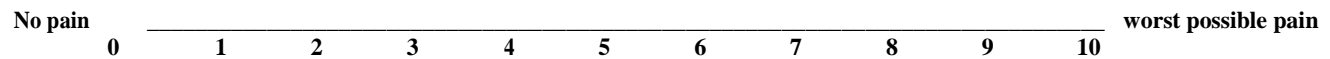
**1 – What is your pain RIGHT NOW?**



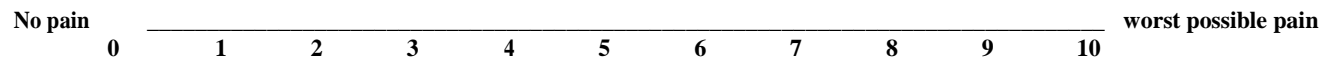
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.



Patient's Name: \_\_\_\_\_

HR#: \_\_\_\_\_

**ACTIVITIES OF LIFE**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying Items	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Weight Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bathing/Showering	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Cardio Exercise	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Eating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Stretching	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Steps	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription medications/drugs you take: \_\_\_\_\_

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

Patient signature: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_



**Medical Information Release Form (HIPAA) & Informed Consent**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse: \_\_\_\_\_

Child(ren): \_\_\_\_\_

Other: \_\_\_\_\_

*This Release of Information will remain in effect until terminated by me in writing.*

**REGARDING: CHIROPRACTIC ADJUSTMENTS, ASSESSMENTS, RE-EVALUATIONS:**

I am aware that after reviewing this document, chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Vitalife Chiropractic have been laid out to my satisfaction. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Patient or Authorized person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**REGARDING: X-RAYS AND IMAGING STUDIES**

By my signature below I am acknowledging that I have reviewed this information and understand that x-ray exposure may cause birth defects and other hazardous effects such as growth and developmental delays of an unborn child (if female is pregnant). I have also conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient or Authorized person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**FEMALES ONLY** → Please read carefully and let a team member know if you have further questions.

The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-\_\_\_\_ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am NOT pregnant.

**OFFICE USE ONLY:**

C AP \_\_\_\_\_ T AP \_\_\_\_\_ L AP \_\_\_\_\_  
C Lat \_\_\_\_\_ T Lat \_\_\_\_\_ L Lat \_\_\_\_\_



Witness Initials

**Vitalife Chiropractic**  
**NOTICE OF PRIVACY PRACTICE**

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive “Detail” Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, or to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call **Dr. Kevin Berg** at **(720) 900-5251**. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

I can receive a copy of Vitalife Chiropractic’s Patient Privacy Notice at any time. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this ‘Notice of Privacy Practice’ at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this “Notice” is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

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

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date