

# WELCOME TO VANDER WEIT CHIROPRACTIC!!!

*Please read and complete this questionnaire in detail.*

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

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

Marital Status: M W D S Spouse's Name: \_\_\_\_\_ Children # and Ages: \_\_\_\_\_

Most patients are referred to our office by family or friends. Who may we thank for referring you? \_\_\_\_\_

Would you like us to file insurance for you? **YES / NO** Is this visit related to an auto accident/work injury? **YES / NO**

**Describe the purpose of your visit today:** \_\_\_\_\_

**If your visit is for a specific condition, when did you first notice it?** \_\_\_\_\_

**Do you know what caused this condition?** YES / NO Describe \_\_\_\_\_

**Since the condition started it is :** Staying about the same Getting better Getting worse

**How often do you suffer from this condition?** Every Day Few times/week Few times/month Few Times/year

**How often is the condition present:** Constant Frequent Intermittent Occasional Infrequent

**Pains are:** Sharp Dull Throbbing Shooting Numbness Tingling Other: \_\_\_\_\_

**Please Circle a number Value:** No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

**What activities make your condition worse?** \_\_\_\_\_

**What activities make your condition better?** \_\_\_\_\_

**What activities does it interfere with:** Work Sleep Walking Sitting Hobbies Other: \_\_\_\_\_

**Have you experienced this in the past?** YES / NO **Have you seen anyone for this condition? If so, what did they do?** \_\_\_\_\_

**Has anyone in your family experienced similar problems?** YES / NO If so, who? \_\_\_\_\_

**Have you ever been to a chiropractor?** YES / NO **When was your last adjustment?** \_\_\_\_\_

**What medications are you currently taking and for what conditions?** \_\_\_\_\_

**Are there any other complaint/conditions that the doctor should address?** If so, list and describe \_\_\_\_\_

**On a scale of 1-10, ten being the highest, please rate your commitment to your treatment at this office...**

**Not very committed** 1 2 3 4 5 6 7 8 9 10 **Very Committed**

**Circle (more than one if applicable) I want to:** *Get out of pain Correct my problem Enhance quality of life*

*Continued on the next page...*

**CERVICAL SPINE (NECK):** Postural distortions from subluxations in your neck will weaken the nerves into your arms, hands and head and can affect these parts of your body. **Please mark an X in all the boxes that apply...**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Neck Pain                            | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Recurrent colds/flu |
| <input type="checkbox"/> Pain into your shoulder              | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Low energy/Fatigue  |
| <input type="checkbox"/> Numbness/tingling in your arms/hands | <input type="checkbox"/> Coldness in hands   | <input type="checkbox"/> TMJ/Pain/Clicking   |
| <input type="checkbox"/> Hearing disturbances                 | <input type="checkbox"/> Thyroid conditions  |  |
| <input type="checkbox"/> Weakness in grip                     | <input type="checkbox"/> Sinusitis           |  |
|   | <input type="checkbox"/> Allergies/hay fever |  |

**THORACIC SPINE (UPPER BACK):** Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. **Please mark an X in all the boxes that apply...**

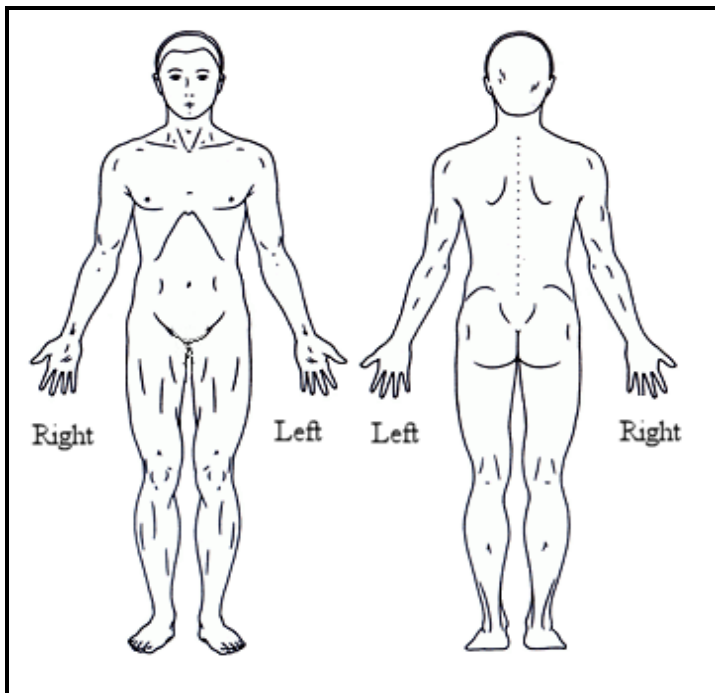
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Upper back pain    | <input type="checkbox"/> Heart attacks /angina               | <input type="checkbox"/> Shortness of breath                  |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Recurrent lung infection/bronchitis | <input type="checkbox"/> Pain on deep inspiration /expiration |
| <input type="checkbox"/> Heart murmurs      |  |   |
| <input type="checkbox"/> Tachycardia        | <input type="checkbox"/> Asthma/wheezing                     |   |

**THORACIC SPINE (MID BACK):** Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest and upper digestive tract and affect these parts of your body. **Please mark an X in all the boxes that apply...**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Mid back pain          | <input type="checkbox"/> Reflux           | <input type="checkbox"/> Tired/irritable after eating or if you haven't eaten in a while. |
| <input type="checkbox"/> Pain into ribs/chest   | <input type="checkbox"/> Nausea           |   |
| <input type="checkbox"/> Indigestion/ heartburn | <input type="checkbox"/> Ulcers/gastritis |   |
| <input type="checkbox"/> Hypoglycemia           |   |   |

**LUMBAR SPINE (LOW BACK):** Postural distortions from subluxations will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. **Please mark an X in all the boxes that apply...**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Low back pain                       | <input type="checkbox"/> Muscle cramps in your legs/feet.            | <input type="checkbox"/> Constipation/Diarrhea    |
| <input type="checkbox"/> Pain into your hips/legs/feet       | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating               | <input type="checkbox"/> Cramping (Females)       |
| <input type="checkbox"/> Coldness in your legs/feet          |  | <input type="checkbox"/> Sexual dysfunction       |



**Please mark on the diagram the areas of discomfort.**

**XXX = Pain**  
**OOO = Numbness**  
**+++ = Tingling**

I hereby authorize Vander Weit Chiropractic to examine me, including x-rays if indicated by my exam and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service. By signing below you certify the accuracy of your medical and/or accident history and further certify that you present to Vander Weit Chiropractic for evaluation and treatment of a health related condition and for no other purpose.

Patient/Legal Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

# VANDER WEIT CHIROPRACTIC

## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND ACCEPTANCE OF CARE

**Chiropractic has only one goal: To eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of gentle forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of infirmity; wholeness, in which all organs, tissues and cells are functioning at 100%.

**Vertebral Subluxation:** A disruption in the normal flow of Life Energy in the nerves between the brain and the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

We do not offer to diagnose or treat any disease or condition other than **vertebral subluxation**. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Scott Vander Weit, or other licensed doctors of Vander Weit 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 named above, including those working at Vander Weit Chiropractic (Practice). I have had an opportunity to discuss with the doctor named above and/or with other office or clinic personal the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; as source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually collected.

I understand and have been provided with a Notice of Information Practices that provides a more completed description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

I have read and fully understand the above statements. I have also had an opportunity to ask questions about it's content, and by 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 condition(s) for which I seek treatment. I therefore accept chiropractic care on this basis.

**Most of our patients are referred from family and friends. When you refer someone special we would like to acknowledge you. Would you allow us to send you a gift certificate for a FREE 30 Minute Massage? YES/NO**

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

\_\_\_\_\_  
Witness to Patients' Signature