



Vitality Chiropractic Center  
768 Shoreline Dr., Aurora, IL 60504  
Phone: (630)499-4078 Fax: (630)499-4079

**Please Complete the Following Information:**

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Email \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

How did you hear about Vitality Chiropractic Center \_\_\_\_\_

Primary reason for visit \_\_\_\_\_

Please List any other Health problems \_\_\_\_\_

When did the symptoms of primary condition appear?  
\_\_\_\_\_

Is the primary condition getting worse? \_\_\_ Yes \_\_\_ No \_\_\_ Unknown

Where is the Pain? \_\_\_\_\_

**Type of Pain:**

- \_\_\_ Shooting
- \_\_\_ Tingling
- \_\_\_ Throbbing
- \_\_\_ Stiffness

- \_\_\_ Swelling
- \_\_\_ Numbness
- \_\_\_ Sharp
- \_\_\_ Dull

- \_\_\_ Cramps
- \_\_\_ Aching
- \_\_\_ Burning
- \_\_\_ Other

**Exercise:**  
\_\_\_ None  
\_\_\_ Moderate  
\_\_\_ Daily  
\_\_\_ Heavy

**Work Activity:**  
\_\_\_ Sitting  
\_\_\_ Standing  
\_\_\_ Light Labor  
\_\_\_ Heavy Labor

**Habits:**  
\_\_\_ Smoking..... \_\_\_ Packs/Day  
\_\_\_ Alcohol..... \_\_\_ Drinks/Week  
\_\_\_ Coffee/Caffeine Drinks.. \_\_\_ Cups/Day  
\_\_\_ High Stress Level..... Reason:

**Injuries Falls You Have Had:**

**Falls:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Head Injuries:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Broken Bones:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Dislocations:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Surgeries:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medications:** \_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_  
\_\_\_\_\_

**Vitamins/Herbs/Minerals:** \_\_\_\_\_  
\_\_\_\_\_





## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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

\_\_\_\_\_  
Date

**\*\*\*\*\*No call, No Show Policy\*\*\*\*\***

**If you can not make your appointment, please try to give us a 24hr notice.**

**\*\*\*No Calls and No Shows will be charged a \$20 fee\*\*\***

We understand everyone is busy and things come up, but please try to call us as soon as possible if you can't make your appointment. We have reserved appointment times especially for you. By calling and letting us know, we can offer other patients your cancelled time. When you cancel your appointment at the last minute or don't call or no show, everyone loses: you, the doctor and other patients that would like to have utilized your appointment time.

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