5140 Sunset Blvd Suite A
Lexington, SC 29072
803.609.8503

Name_____ Date____/____/_____

Date of Birth____/____/_____ Age_____ Male/Female Social Security Number _____

Address_____City_____State_____Zip_____

Phone: Home_____ Cell_____ Cell Phone Provider_____

Email_____ Employer's Name_____Position_____

In case of emergency contact: _____ Phone Number:_____

Single Married Divorced Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

Who may we thank for referring you?_____

Insurance Information

Name of Primary Insurance Carrier: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

Do you have a HSA/FSA? (Health/Flexible Savings Account) ☐ YES ☐ NO

Name of Secondary Insurance Carrier: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1= mild 10 =unbearable	When did this episode Start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

ADD/ADHD	**DIGESTIVE PROBLEMS**	**KNEE PAIN**	**PAIN IN KNEE**
ALLERGIES	**DISC PROBLEM**	**LEG PAIN**	**PERSISTENT COUGH**
ANXIETY	**DIZZINESS**	**LIVER DISEASE**	**RASH**
ARM PAIN	**EAR INFECTIONS**	**LOW BACK PAIN**	**SEIZURES**
ARTHRITIS	**EPILEPSY**	**LUPUS**	**SLEEPING PROBLEMS**
ASTHMA	**FAINTING**	**MENSTRUAL ISSUES**	**NERVOUSNESS**
AUTISM	**FIBROMYALGIA**	**MID BACK PAIN**	**NUMBNESS IN HAND**
AUTOIMMUNE	**GASTRIC REFLUX**	**MIGRAINES**	**PAIN IN ELBOW**
BACK TROUBLE	**HEADACHES**	**NAUSEA**	**PAIN IN WRIST**
BEDWETTING	**HEART PROBLEMS**	**NUMBNESS IN ARMS**	**PREGNANCY ISSUES**
BLADDER PROBLEMS	**HEARTBURN**	**NUMBNESS IN LEGS**	**RINGING IN EARS**
CANCER	**HEMORRHOIDS**	**PAIN IN FOOT**	**SHOULDER PAIN**
CARPAL TUNNEL	**HERNIA**	**PAINFUL JOINTS**	**STOMACH ISSUES**
CHEST PAIN	**HIP PAIN**	**PROSTATE TROUBLE**	**SWEATS**
CHILLS	**HIVES**	**SCIATICA**	**THYROID PROBLEMS**
CHRONIC FATIGUE	**HYPERTENSION**	**SINUS INFECTIONS**	**TMJ (JAW PAIN)**
COLIC	**IMMUNE DEFICIENT**	**NECK PAIN**	**ULCERS**
CONSTIPATION	**INFERTILITY**	**NUMBNESS IN FEET**	**VERTIGO**
DEPRESSION	**IRRITABLE BOWEL**	**PAIN IN ANKLE**	**WEIGHT LOSS**
DIABETES	**KIDNEY PROBLEMS**	**OTHER_____**	**_____**

CIRCLE ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD

STROKE **HEART DISEASE** **SPINAL SURGERY** **SEIZURES** **SPINAL FRACTURE** **SCOLIOSIS** **DIABETES**

LIST ALL SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON_____

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YES, DR AND DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA_____

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

- I give VITAL CHIROPRACTIC permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If VITAL CHIROPRACTIC contacts me by phone, I give them permission to leave a message on my voice mail or answering machine.
- I give VITAL CHIROPRACTIC permission to use my name on the welcome board, referral board, birthday board, prize winning notices, and community information (i.e. newspaper clippings).
- VITAL CHIROPRACTIC may use a sign-in sheet at the registration desk where you will be asked to sign your name, may call you by name in the waiting room when your physician is ready to see you
- I give VITAL CHIROPRACTIC permission to adjust me in a semi-closed room setting where other patients and office staff may able to overhear some of my PHI during the course of care. This semi-closed room environment is used for ongoing care, and is not the environment used for taking patient histories, performing examinations, or presenting report of findings, as these procedures are completed in a private, confidential setting.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

SIGNED_____ **DATE**_____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

PLEASE PRINT YOUR NAME HERE **DATE**

PLEASE PLACE AN "X" IN THE APPROPRIATE BOXES BELOW

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SINUS TROUBLE					
SURGERIES					
TMJ					

REALEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Samantha Messina, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED_____ **DATE**_____

TERMS OF ACCEPTANCE/ CONSENT TO TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. 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 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 disease or infirmity.
Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which is caused by an alteration of nervous system function and interference with the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic neurological 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 another health care provider.
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 ONLY PRACTICE OBJECTIVE is to find and remove vertebral subluxations. Our only method is specific adjusting to correct neurological subluxations.
I hereby consent to and authorize the administration of all diagnostic and chiropractic treatments that may be considered advisable or necessary in the judgment of Vital Chiropractic, LLC. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that while Vital Chiropractic, LLC may prepare necessary reports and forms to assist me in making collections from the insurance company, all services rendered to me are charged directly to me and I am personally responsible for payment.
By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

SIGNED_____ **DATE**_____

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD_____
I AUTHORIZE DR. SAMANTHA MESSINA AND JOSEPH MESSINA AND ANY AND ALL VITAL CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELEY NOTIFY VITAL CHIROPRACTIC IN WRITING.

_____ _____ _____
GUARDIAN SIGNATURE **GUARDIAN'S RELATIONSHIP TO MINOR** **DATE**