5140 Sunset Blvd Suite A
Lexington, SC 29072
803.609.8503

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

RELEASE 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**

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____

Name:_____