VIBRANT HEALTH CHIROPRACTIC

PATIENT INFORMATION

Patient Name: ______________________________

Date: ____________ Sex: M / F / Other Date of Birth: ____________

Address: ______________________________

City: ____________ State: ________ Zip: ________

Primary Phone #: ____________ Alt. Phone #: ____________

Email: ______________________________

Married: ____ Widow: ____ Single: ____

Separated: ____ Divorced: ____ Partnered: ____

Occupation: ____________ Employer: ____________

Work Duties: ______________________________

Employer Phone #: ____________

Emergency Contact: ______________________________

Phone #: ____________ Relationship: ____________

Referred by: ______________________________

REASON FOR SEEKING CARE

Primary Complaint: ______________________________

Secondary Complaint: ______________________________

Other Complaints: ______________________________

When did the symptoms begin? ______________________________

Initial cause of symptoms: ______________________________

____

How often do you experience these symptoms? ______________________________

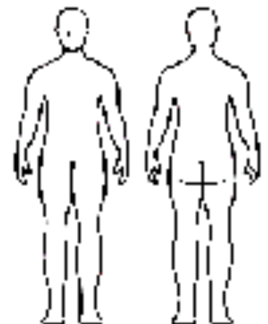
What time of the day do you experience these symptoms? ______________________________

Are the symptoms constant or come and go? ______________________________

Are the symptoms the same or getting worse? ______________________________

Does it interfere with: Work ___ Sleep ___ Recreation ___ Daily Routine ___

Mark an 'X' on the picture where the symptoms are experienced:



Type of symptoms: Sharp ___ Dull ___ Throbbing ___ Numb ___ Tingling ___

Burning ___ Aching ___ Cramps ___ Stiffness ___ Swelling ___

Severity rating: 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (1=no pain/ 10= worst pain)

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HEALTH HISTORY

What other doctors/specialists have you seen for your condition? ______________________________

____

What treatment have you received? ______________________________

Last date of: Physical exam ____________ X-ray ____________ Spinal exam ____________

Height: ____________ Weight: ____________

Place a mark on ☐ to indicate if you have had any of the following:

- ☐ Abdominal Pain
- ☐ Allergies
- ☐ Angina
- ☐ Anorexia
- ☐ Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast soreness
- ☐ Bulimia
- ☐ Cancer
- ☐ Colitis
- ☐ Convulsions
- ☐ Diabetes
- ☐ Dislocated joints
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart attacks
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irregular bowel habits
- ☐ Irregular menstrual
- ☐ Irritable colon
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Painful urination
- ☐ PMS
- ☐ Polio
- ☐ Profuse Menstrual
- ☐ Prostate disease
- ☐ Rapid heart rate
- ☐ Rheumatic fever
- ☐ Scoliosis
- ☐ Sexually transmitted diseases
- ☐ Sickle cell anemia
- ☐ Sinus trouble
- ☐ Spinal disc disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vaginal discharge

INJURIES/SURGERIES YOU HAVE HAD: Date of occurrence

Falls ______________________________ ____________

Head injury ______________________________ ____________

Broken bones ______________________________ ____________

Dislocations ______________________________ ____________

Surgeries ______________________________ ____________

EXERCISE	WORK ACTIVITY	HABITS	
___ None	___ Sitting	___ Smoking	Packs/Day ____________
___ Moderate	___ Standing	___ Alcohol	Drinks/week ____________
___ Daily	___ Light Labor	___ Caffeine Drink	Cups/day ____________
___ Heavy	___ Heavy Labor	___ High Stress	Reason ____________

Are you pregnant? ___ Yes ___No Due Date ______________________

FAMILY HISTORY

Illnesses on Maternal Side ______________________________

Illnesses on Paternal Side ______________________________

ALLERGIES/MEDICATIONS

____

VIBRANT HEALTH CHIROPRACTIC
Dr. Michael Q. Robles DC
4133 Mohr Ave. Suite i,
Pleasanton, CA 94566
925-404-4240

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I have had an opportunity to discuss with my chiropractor the nature and purpose of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. I understand the results are not guaranteed and there will be no diagnosis or treatment of any disease.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and orthopedic tests, on me (or on the patient named below, for whom I am legally responsible) which are recommended by my chiropractor and/or other licensed Doctors of Chiropractic who now or in the future render treatment to me while working for, associated with, or serving as back-up for my chiropractor.

I understand and am informed that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
PLEASE CHECK THE STATEMENT AND SIGN BELOW

☐ I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my chiropractor and have had my questions answered to my satisfaction. By signing below I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give by consent to treatment.

Patient Name (please print): ____

______________________________________ ________________
Patient/Legal Guardian Signature Date

______________________________________ ________________
Providing D.C. Signature Date

January 15, 2018

NOTICE: PATIENT PRIVACY

At Vibrant Health Chiropractic, we are committed to preserving the privacy of your health information. In fact, we are required by law to protect the Privacy of your health information and to provide you with a notice describing how health information about you may be used and disclosed and how you can access this information.

We may be required or permitted by certain laws to use or disclose your health information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your health information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your health information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and notifying if your rights have been violated.

We have provided you with this notice, which fully explains your rights and our obligations under the law. We may revise our notice from time to time. The effective date at the top right corner of this page indicates the date of the most current notice in effect.

You have the right to receive a copy of our most current notice at any time; simply ask and you will be provided with one.

If you have any questions, concerns or complaints about the Notice or your health information, please contact Dr. Michael Robles, our privacy officer at our office at:

4133 Mohr Ave. Suite i,
Pleasanton, CA 94566
925-404-4240

Acknowledgement of Receipt of Notice of Privacy Practices
(detach and retain in file)

I acknowledge that Vibrant Health Chiropractic's Notice of Privacy Practices has been provided to me. I understand that I have a right to review Vibrant Health Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in performance of health care operations of Vibrant Health Chiropractic. The Notice of Privacy Practices of Vibrant Health Chiropractic is also provided on request at the main administration desk (front desk) of the practice.

The Notice of Privacy Practices also describes my rights and Vibrant Health Chiropractic's duties with respect to my protected health information. Vibrant Health Chiropractic reserves the right to change the Notice of Privacy Practices at any time. I understand that I may request a copy of the revised policy at any time by requesting a revised copy be sent by mail, or asking for one at the time of my next appointment.

____ ____________________
Patient Name (please print) Date

____ ____________________
Patient/Legal Guardian Signature Date