VITAL BALANCE
CHIROPRACTIC

New Patient Information:

Name_____ Sex *M F* Age_____ Date_____

Birthdate_____ SSN_____ E-mail_____

Address_____ City_____ State_____ Zip_____

Home_____ Business_____ Fax_____ Cell_____

Occupation_____ Employer_____

Name/Age of Children_____ Marital Status (circle one) *M S D W*

Spouse/Partner Name and Occupation_____

Emergency Contact Number_____ Relationship_____

Have you ever been to a Chiropractor before? *Y N* Name of Doctor_____

Name and Number of Medical Doctor_____

How did you hear about our office?_____

Health Evaluation:

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where pain travels when appropriate. You can also write notes next to your markings if a description would be helpful. Then, please answer the questions by circling the number that best represents your pain, where **1 is no pain** and **10 is the worst pain you can imagine.**

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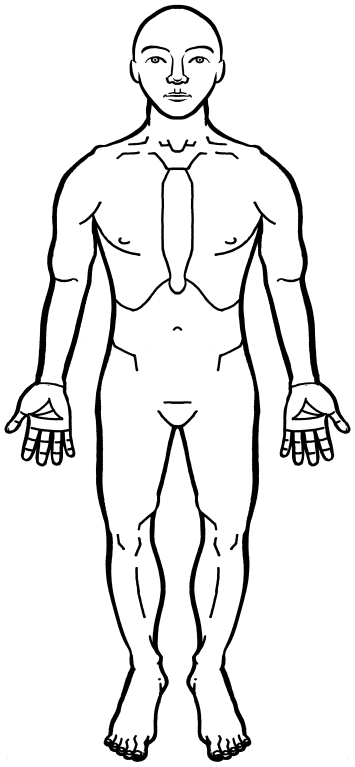
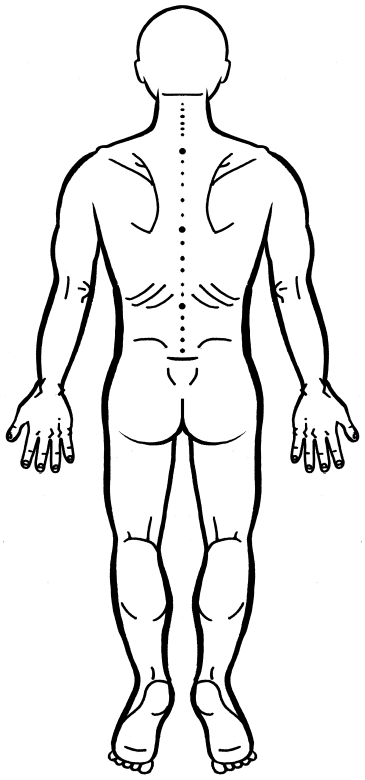
CHIROPRACTIC





Rate your pain at its **WORST** in the past 24 hours:

1 2 3 4 5 6 7 8 9 10

Rate your pain at its **BEST** in the past 24 hours:

1 2 3 4 5 6 7 8 9 10

Rate your pain at its **AVERAGE** in the past 24 hours:

1 2 3 4 5 6 7 8 9 10

Complaints Please rank your health complaints and rate their severity (1-10, 10 being the worst). This could include your current pain, chronic injuries, or general health concerns.

_____

_____

_____

_____

Goals What are your goals for seeking care in our office? _____

_____

Stress Level Rate your current stress levels on a scale of 1-10, 10 being the most stress._____

Reasons for stress _____

_____

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Exercise Do you exercise? _____ How often? _____ How long each session? _____
What type of exercise do you do? _____

Smoking Do you smoke? _____ How much? _____ How long have you been smoking? _____

Fluids/Vitamins For each item listed please indicate the frequency that you consume them (i.e. 2 cups/day).
Coffee _____ Tea _____ Soda _____ Alcohol _____
Water _____ Vitamins/Supplements _____

Allergies List any known allergies, including food, seasonal, drug, animal, etc. _____
_____

Medical Care

Please describe any condition for which you are currently under the care of a physician.
Diagnosis _____ Onset _____
Doctor(s) involved _____
How diagnosed (labs/tests) _____
Current treatment (medication/therapy) _____
Past treatments, if any _____
Please list any medications you are currently taking, the reason for taking them, and for how long.
Medications _____
_____
Please list any surgeries, operations, fractures, car accidents, etc. that you've had.
Surgeries/Hospitalizations _____
_____

Family History

Please list and identify the family member with any of these conditions:

Arthritis	_____	Outcome	_____
Blood Disorders	_____	Outcome	_____
Cancer	_____	Outcome	_____
Diabetes	_____	Outcome	_____
Epilepsy	_____	Outcome	_____
Mental Disease	_____	Outcome	_____
Heart Disease	_____	Outcome	_____
Other	_____	Outcome	_____

Review of Systems

Please Mark any that Apply to **You**

	Currently	Past	Description
Fatigue	____	____	_____
Weight Loss	____	____	_____
Weight Gain	____	____	_____
Sleeping Disorders	____	____	_____
Arthritis	____	____	_____
Diabetes	____	____	_____

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Head Trauma	____	____	_____
Memory Loss	____	____	_____
Headache	____	____	_____
Light Sensitivity	____	____	_____
Dizziness/Vertigo	____	____	_____
Ringing/Buzzing in Ears	____	____	_____
Loss of Balance	____	____	_____
Fainting	____	____	_____
Stroke	____	____	_____
Sinus Problems	____	____	_____
Difficulty Breathing	____	____	_____
Thyroid Conditions	____	____	_____
Hypertension	____	____	_____
Hypotension	____	____	_____
Heart Condition	____	____	_____
Chest Pains	____	____	_____
Abdominal Pain	____	____	_____
Digestive Complaints	____	____	_____
Gallbladder Conditions	____	____	_____
Kidney Conditions	____	____	_____
Difficulty Urinating	____	____	_____
Ankle Swelling	____	____	_____
Cancer/Tumor	____	____	_____
Fractures/Dislocations	____	____	_____
Joint Pain/Stiffness	____	____	_____
Bone Pain	____	____	_____
Numbness	____	____	_____
Weakness in Arms/Legs	____	____	_____
Pins and Needles in Arms/Legs	____	____	_____
Skin Disorders	____	____	_____
Menstrual Difficulties	____	____	_____
Pregnancy	____	____	_____

Additional Comments and Information

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Office Guidelines and Policies

Welcome! Please take the time to review the following office policies and guidelines so that we may better serve you.

Medical Records

Please bring applicable copies of your latest laboratory and imaging (x-ray, MRI, CT) reports on the day of your initial exam. Please note that copies brought in will become part of our office records. If your doctor requires an 'Authorization to Release Medical Records' form please contact our office.

Retail Sales

Vital Balance Chiropractic, LLC often recommends nutritional support protocols (vitamins, minerals, enzymes, etc.) specific taping procedures, and exercise tools. Dr. Kenneth Kao and Dr. Rachel Yan have carefully selected excellent quality 'professional grade' products from various reputable manufacturers. The costs of these products are not included in the evaluation or treatment fees. Patients are never required to purchase products from our office.

Payment Policies

All payments are due at time of services are rendered. We accept cash, check, and credit card. Vital Balance Chiropractic, LLC is not a member of any HMO, PPO, or other provider networks, nor do we provide any billing services for your insurance. Any coverage you may have for services provided at this office will be deemed "out of network coverage" by your insurance company and we have no part in if, or how much you receive. Application for any outside coverage must be filled and submitted by the patient. Vital Balance Chiropractic, LLC does not take part in Medicare or Personal Injury. Current patients will be released to an appropriate provider.

No Show & Cancellation Policy

The doctors at Vital Balance Chiropractic, LLC are committed to offering the best services and devote the best resources available to your appointment, therefore, require a minimum 24-hour cancellation notice on all appointments. No-shows or cancellations with less than a 24-hour notice will be charged half the full fee of the appointment.

Return Policy

Product returns must be made within thirty (30) days of purchase. Un-opened products that are returned within 30 days will be given a full refund. All supplement returns must be unopened and sealed inside the original packaging. Opened supplements may not be returned. No refunds are offered on services rendered.

Print Name _____

Signed _____ Date _____

VITAL BALANCE
CHIROPRACTIC

Informed Consent

Medical doctors, doctors of chiropractic, osteopaths and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative, noninvasive treatment to my joints and soft tissues. I understand that the procedures may consist of manipulations or adjustments involving the movement of the joints and soft tissues. Physical therapy, home exercises, nutritional supplements, ergonomic, nutritional and lifestyle changes may also be recommended.

Routine chiropractic examination and treatment involve some of the following methods:

• Inspection: Assessment/appraisal of your body in all postures. All symptomatic and painful body parts may be viewed which may require gowning to access the affected area. Women are encouraged to request a female observer at any time during the examination and/or treatment.
• Auscultation: Auditory assessment of blood pressure and other body sounds.
• Palpation: Hands on assessment by the doctor to feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues and other abnormalities.
• Percussion: Diagnosis using a rubber hammer to tap on bones or tendons.
• Orthopedic and Neurological tests: Standard diagnostic tests to assess your neuromusculoskeletal systems.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems I am aware that there are possible risks and complications associated with these procedures:

• Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.
• Dizziness: Temporary symptoms like dizziness and nausea may occur but are relatively rare. Please inform your doctor immediately if you experience any of these symptoms.
• Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, degeneration, deformities or pathologies, such as weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, a degenerative disc or other abnormality is detected our office will proceed with extra caution.
• Stroke: Although strokes occur with some frequency in the general population, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage, including stroke, is reported to occur once in one million to once in ten million treatments. Once in one million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

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Treatment Results

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no absolute certainty that I will achieve these results. I realize that the practice of medicine including chiropractic is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by the doctors of Vital Balance Chiropractic.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
• Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, have undesirable side-effects, cause physical or psychological dependence and may have to be continued indefinitely. Some medications may involve serious risks.
• Rest/Home therapy: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones, muscle atrophy and joint stiffness.
• Surgery: Surgery may be necessary for conditions such as joint instability or serious disc rupture, among others. Surgical risks may include unsuccessful outcomes, complications, pain, reaction to anesthesia and prolonged recovery.
• Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor, if necessary, has provided further explanation and I am satisfied with my understanding of this informed consent. I have made my decision voluntarily and of my own free will. To attest to my consent to these examination and treatment procedures I hereby affix my signature to this Informed Consent document.

Patient's signature: _____ Date: _____

I have explained the procedures, alternatives and risks in conference with the patient.

Doctor's signature: _____ Date: _____

VITAL BALANCE
CHIROPRACTIC

Privacy and Medical Disclosure

In the course of your care as a patient at Vital Balance Chiropractic, LLC, your doctor(s) may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your name, address, phone number, email and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We typically provide information about your health care to you in person at the time you receive health care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

VITAL BALANCE
CHIROPRACTIC

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to your doctor at Vital Balance Chiropractic, LLC. If you would like further information about our privacy policies and practices, please contact Dr. Kenneth Kao, D.C. or Dr. Rachel Yan, D.C.

This notice is effective as of 04/09/2009. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

My signature acknowledges that I have read and understand the contents of this notice.

_____ _____ _____
Name (Printed) Signature Date

If the patient is a minor, or if the patient is being represented by another party:

_____ _____ _____
Personal Representative Name (Printed) Personal Representative Signature Date

_____
Description of the authority to act on behalf of the patient