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IT IS OUR OFFICE POLICY TO CHARGE 35.00 FOR ALL APPOINTMENTS NOT CANCELLED OR RESCHEDULED PRIOR TO 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME. THIS FEE IS YOUR RESPONSIBILITY AND WILL BE BILLED DIRECTLY TO YOU.

SIGNATURE_____ DATE_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

With respect to _____,

(Patient Name)

I hereby authorize VIA DANTE, INC., d/b/a VITRUVIAN CHIROPRACTIC CENTER,RANSOM J. MORIN, D.C., their Employees and Business Associates to furnish the following Doctor(s)/Center(s) _____, all "protected health information" and reports which may be requested in connection with the presentation of claims related to all of the conditions/ treatments for the above named patient.

Signed_____Date_____

(Patient/Guardian Signature)

I hereby authorize_____their Employees and Business Associates to furnish VIA DANTE, INC., d/b/a VITRUVIAN CHIROPRACTIC CENTER, RANSOM J. MORIN, D.C., all "protected health information" and reports which may be requested in connection with the presentation of claims related to all of the conditions/ treatments for the above named patient.

Signed_____Date_____

(Patient/Guardian Signature)

PATIENT INFORMATION

PLEASE COMPLETE ALL LINES. PRINT ALL INFORMATION.

Last Name | First Name | MI

Street Address | City | State | Zip Code

Home Phone No. | Work Phone No. | Cell Phone No.

Date of Birth | Social Security No. | Sex | Marital Status

Employer | Occupation | Student

Employer's Address | City | State | Zip Code

Nearest Relative | Address | Phone No.

Billing Responsibility (Send Bills To)

Last Name | First Name | MI

Street Address | City | State | Zip Code

Employer | Occupation | Student

Employer's Address | City | State | Zip Code

Insurance Information

Insurance Company Name | Insurance ID No. – Claim No.

Subscriber – Insured Party | Date of Birth | Social Security No. | Relationship

Other Insurance Company Name | Insurance ID No. – Claim No.

Subscriber – Insured Party | Date of Birth | Social Security No. | Relationship

Referring Physician | Address of Referring Physician

Date of Accident | Accident Location (Auto, Home, Work, Etc.)

VITRUVIAN
Wellness Center

Name: _____ Date_____

Rate your level of pain with the Pain Scale (VAS):

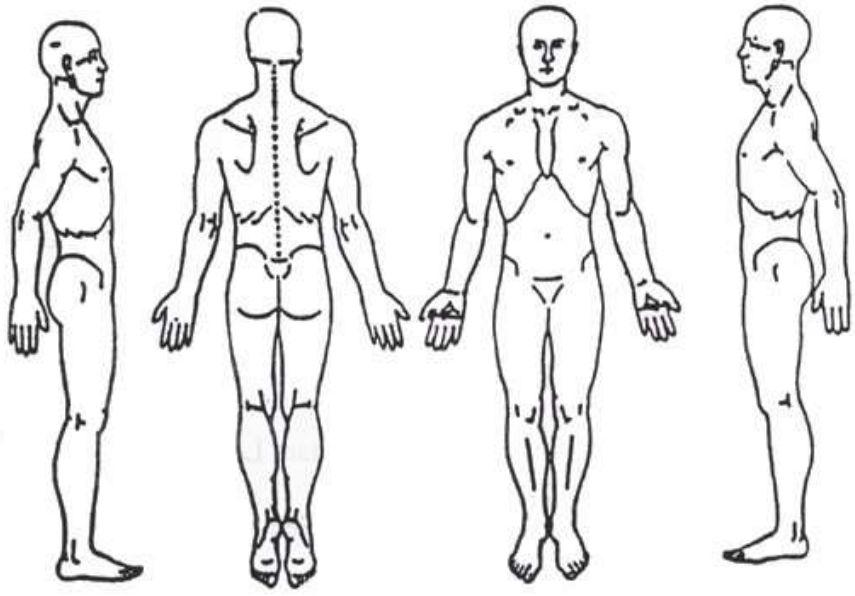
Rate your pain level by marking the appropriate box that best describes your level of pain on a scale of 0 – 10.

	No Pain	1	2	3	4	5	6	7	8	9	10 Intense Pain
What is your pain right now?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
What is your typical or average pain?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
What is your pain at its worst?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Show us where you hurt using this Pain Diagram:

Please DRAW us what your PAIN is by SHADING IT IN ON THE BODY DIAGRAM below.
Be as accurate as you can, and do NOT use "X"s and arrows.

Use the following descriptors of your pain and show where they are on the body diagram
A: Achy N: Numb S: Sharp T: Tight SB: Stabbing P: Pins and Needles



CURRENT MEDICATIONS/SUPPLEMENTS OR OVER THE COUNTER ITEMS CURRENTLY BEING USED.

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

How many of the following do you consume on a daily basis?
Coffee (Cups) _____ Tea (Cups) _____ Alcohol (Drinks) _____Water (Cups) _____ Cigarettes_____

Have you had any significant accidents, injuries or illnesses?

_____

Hospitalizations or surgeries you have had, and your age at the time:

_____

Are you pregnant N Y – How far along? _____ Do you have a pacemaker/defibrillator? _____

Is there anything else you think the doctor should know concerning your condition? No Yes_____

_____

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

TERMS OF ACCEPTANCE

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 bas only one goal, it is important that each patient understand both the objective and the method that will be able 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 infinity

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to 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 vertebral subluxation. However, if during the course of a chiropractic spinal evaluation we encounter non-chiropractic or unusual finding we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

Signature: _____ Date:_____

PATIENT ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____(Print name) ____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request, The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is also provided at the front desk. I may also request a copy from this office at any time via US Mail.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand

_____ _____
(Signature of Patient/ Guardian) (Date)

_____
(Patient/Guardian's name printed)

VITRUVIAN
Wellness Center

Welcome To Vitruvian Wellness Center

First Name _____ MI ____ Last _____ Birth Date ___/___/___ Age _____

Email Address _____ Home Phone No. _____ Cell Phone No. _____

Employer: _____ Occupation _____

Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

Have you ever been to a chiropractor before? Y / N When was your last adjustment _____

Your Health Profile

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both
___Headaches/Migraines
___Fractured Bones
___Swollen Painful Joints
___Anemia
___Pain w/ Cough / Sneeze
___Heart Problems
___Prostate Problems
___Dizziness/Vertigo
___Fatigue
___Colon Trouble
___Cold feet
___Foot Problems
___Cold Sweats
___High Blood pressure
___Cancer (Type) _____

___Hip Pain R / L
___Arthritis
___Convulsions/Epilepsy
___Tremors
___Chest Pain
___Stroke
___Kidney Trouble
___Buzzing/Ringing in ears
___Depression
___Sleeping Problems
___Bed Wetting
___Shortness of Breath
___Light Bothers Eyes
___PMS
___Other

___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L Both
___Neck Stiffness/ Pain
___Frequent Colds / Flu
___Skin Problems
___Blurred Vision R / L
___Lung Problems
___Gall Bladder Problems
___Loss of Smell
___Sinus Problems/Allergies
___Irritability/Mood Swings
___Cold Hands
___Recurring Infection
___Hot Flashes
___Problems Urinating
___Menopause

___Back Stiffness/Pain
___Diabetes
___Cancer
___Double Vision R / L
___Loss of Taste
___Digestive Problems
___Loss of Balance
___Nervousness/Anxiety
___Tension/Stress
___Stomach Upset
___Diarrhea/Constip./Gas
___Jaw/TMJ Problems
___Heartburn/Reflux
___Ulcers

Additional Explanation:

_____

Current Health Condition

Chief Complaint (why you are here today): _____

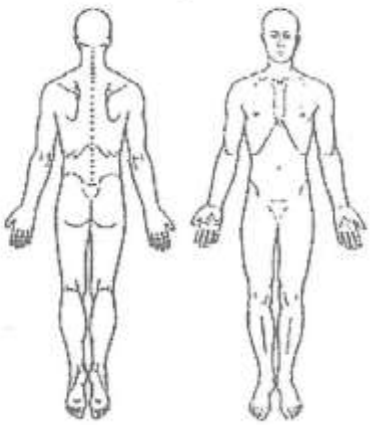
_____

When did this condition begin? _____ Has it ever occurred before: ☐ Yes ☐ No
Was this due to an accident/Trauma? ☐ Yes ☐ No
If Yes, explain. (ex. fall, auto, sports,)

_____

Symptoms: When this problem is at its worst, can you explain in your words how exactly it feels? _____
Severity: ☐ Mild ☐ Moderate ☐ Severe
Does this pain travel or radiate? If so, Where? _____
Quality: (mark all that apply)
☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling ☐ Radiating ☐ Other _____
Is there anything that makes this better or worse? _____

Please mark on the diagram below, the areas of your discomfort



Timing of Symptoms:

☐ Worse Am ☐ Worse Pm ☐ Worse with activity ☐ Worse Sleeping

☐ Occasional (0-25%) ☐ Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)

How often do you find yourself suffering from this problem? _____

How long does the problem last? (All the details of timing) _____

What solutions have you attempted to solve this problem? _____

DAILY ACTIVITIES: EFFECTS OF CURRENT CONDITION ON PERFORMANCE

Carrying Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Changing Positions	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Climbing Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Lifting Children	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Reading/ Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Self-Care – Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Self-Care – Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Self-Care – Shaving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Sitting Still	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Standing Still	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Yard Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform

Please list any effects that this may have on any recreational activities:_____

_____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

_____

Your Primary Dr.: _____ Phone Number: _____

Have you seen your Doctor or anyone else for this/these conditions? No Yes

Doctor's Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Diagnosis by your Doctor: _____

Lab work completed, if any: _____