

Patient Intake

PLEASE PRESENT INSURANCE CARD(S) AND DRIVER'S LICENSE TO BE COPIED

Patient Name: _____

Gender (M / F) Age _____ DOB: _____

Address: _____

City _____ State _____ Zip Code _____

Home Phone # _____

Cell Phone # _____

E-mail Address _____

Married Single Widowed Divorced Separated

Where are you employed? _____

Address: _____

City _____ State _____ Zip Code _____

Work Phone # _____

Emergency Contact Person: _____

Phone # _____

Referred to our office by _____

Primary Medical Doctor: _____

City _____ Phone: _____

Can we contact him/her? Yes No

Is this injury work related? Yes No

Is this injury a result of an auto accident? Yes No

INSURANCE (Fill out only if insurance is not in your name)

Guarantor's Name: _____

Relationship to self: _____

Guarantor's Address: _____

City _____ State _____ Zip Code _____

Date of Birth: _____

Where are they employed? _____

Employer's Address: _____

City _____ State _____ Zip Code _____

Major Complaint
(Please describe only your major complaint)

Designation of Authorization and Payment Agreement:

I do hereby designate Dr. Michael Vanella and Vanella Chiropractic to the fullest extent possible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560 - 503 - 1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or health care expense(s) incurred as a result of the services I receive from the above names doctor. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance including co - pays and deductibles. In the event of non - payment, my account may be turned over to a collection agency or attorney, and I will also be responsible for the cost of collection, and/or 33.3% for legal fees, and does further agree to pay interest on the unpaid balance at the rate of 18% per annum from the date that said monies became due and payable. This notice is effective as of today and will expire seven years after the date on which you last received services from us.

Patient's Signature

Date

Vanella Chiropractic, PLC
4667 Haygood Road, Suite 503-C
Virginia Beach, VA 23455
757-270-1333

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- All treatment provided in this office
- To collect payment
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety/situations.
- To medical examiners, coroners, or funeral directors to aid in identifying you or to help them in performing their duties.
- To organ, tissue, and other donations organizations, upon proximate to your death, if we have no indication on hand about your donation preferences (or a positive indication).

Special cases

- To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
- In fundraising for ourselves.
- To the sponsor of your health plan

Other

All other uses and disclosures by us will require us to obtain your written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

Restrictions: To request restricted access to all or part of your PHI. To do this, inform the office in writing of your request. We are not required to grant your request.

Confidential communications: To receive correspondence of confidential information by alternate means or location. To do this, inform the office in writing of your request.

Access: To inspect or receive copies of your PHI. To do this, just give the office 24 hours notice to make copies.

Amendments: To request changes be made to your PHI. To do this, inform the office in writing of your request. We are not required to grant your request.

Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, just give the office 24 hours notice.

This notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Dept. of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us make submit it in writing. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: For more information about our privacy practices, please contact:

Dr. Michael Vanella
4667 Haygood Rd. #503C
Virginia Beach, VA 23455
757-270-1333

I acknowledge receipt of this notice:

Signature

Date

Print Name

Comprehensive Medical History

Patient Name: _____

FAMILY HISTORY

Diabetes Heart Kidney Cancer Back

Mother - Living	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father - Living	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s), #	_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s), #	_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Smoking Daily Weekly How much? _____

Alcohol Daily Weekly How much? _____

Coffee Daily Weekly How much? _____

Soda Daily Weekly How much? _____

Water Daily Weekly How much? _____

Exercising Daily Weekly How much? _____

Pain relievers Daily Weekly How much? _____

Prayer or meditation? Yes No

Job stress? Yes No

Financial peace? Yes No

Mercury fillings? Yes No

Recreational drugs? Yes No

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Polio
<input type="checkbox"/> Cancer	<input type="checkbox"/> Influenza	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Low Back pain	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Sacroiliac Sprain
<input type="checkbox"/> Eczema	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Whiplash

Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please enter "2" (Previously) or "3" (Presently) in front of all of the following signs and symptoms. Leave blank if not applicable.

GENERAL SYMPTOMS

___ Headache

___ Fever

___ Chills

___ Night Sweats

___ Fainting

___ Dizziness

___ Convulsions

___ Loss of Sleep

___ Fatigue

___ Nervousness

___ Loss of Weight

___ Numbness in arm/leg

___ Pain in arm/leg

___ Allergy

___ Wheezing

___ Neuralgia

GASTRO-INTESTINAL

___ Poor Appetite

___ Poor Digestion

___ Starvation

___ Belching or Gas

___ Nausea

___ Vomiting

___ Vomiting Blood

___ Pain Over Stomach

___ Constipation

___ Diarrhea

___ Colon Trouble

___ Hemorrhoids (piles)

___ Fluid Retention

___ Liver Trouble

___ Gout

___ Jaundice

___ Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

___ Poor Vision

___ Crossed Eyes

___ Pain in Eyes

___ Deafness

___ Earache

___ Ear Noises

___ Ear Discharge

___ Nasal Obstruction

___ Nosed Bleeds

___ Sore Throats

___ Hoarseness

___ Hay Fever

___ Asthma

___ Frequent Colds

___ Enlarged Thyroid

___ Tonsillitis

___ Sinus Trouble

RESPIRATORY

___ Chronic Cough

___ Spitting Blood

___ Spitting Phlegm

___ Chest Pain

___ Difficulty Breathing

GENITO-URINARY

___ Frequent Urination

___ Painful Urination

___ Blood in Urine

___ Kidney Infection

___ Bed Wetting

___ Inability to control urine

___ Prostate Trouble

MUSCLES & JOINTS

___ Weakness

___ Twitching

___ Stiff Neck

___ Backache

___ Swollen Joints

___ Tremors

___ Foot Trouble

___ Flat Feet

___ Painful Tail Bone

___ Pain Between Shoulders

___ Spinal Curvature

CARDIO-VASCULAR

___ Rapid Heart

___ Slow Heart

___ High Blood Pressure

___ Low Blood Pressure

___ Pain Over Heart

___ Heart Trouble

___ Swelling Ankles

___ Poor Circulation

___ Varicose Veins

___ Strokes

___ Palpitations

SKIN OR ALLERGIES

___ Skin Eruptions

___ Itching

___ Bruises Easily

___ Dryness

___ Boils

___ Sensitive Skin

___ Hives

___ Eczema

FOR WOMEN ONLY

___ Painful Periods

___ Excessive Flow

___ Irregular Cycle

___ Hot Flashes

___ Cramps/Backaches

___ Vaginal Discharge

___ Pregnant at this time

___ Last Pap _____

IN PATIENT / OUT PATIENT OPERATIONS & PROCEDURES - HOSPITALIZATION

DATE	DATE	DATE	DATE
_____ Back Operations	_____ Tubes in Ears	_____ Rectal Surgery	_____ Thyroid
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia	_____ Stomach
_____ Bypass surgery	_____ Cancer	_____ Cosmetic Surgery	_____ Eye surgery
_____ Gall Bladder	_____ Female Organs	_____ Elective surgery _____	
_____ Knee Operation	_____ C Section	_____ Other _____	

LIST ANY ACCIDENTS or FALLS

Car _____
 Recreational Vehicle _____
 Sports _____
 School _____
 Other _____
 Other _____

Have you been knocked unconscious? _____

List any broken bones (fractures) or dislocations: _____

Have you ever been on crutches? Yes No Why? _____

Are you presently taking any medication - prescription or over-the-counter? Yes No List: _____

Are you presently taking supplements or homeopathic products? Yes No List: _____

How does your current condition interfere with your:

Work or career: _____ Recreational activities: _____

Household responsibilities : _____ Personal relationships: _____

How much sleep do you average per night? ____ hours What is the approximate age of your mattress: _____

Describe your eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

What is the major stress in your life? _____

AUTHORIZATION

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, and fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat any condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Patient Signature

Date

Print Name

Vanella Chiropractic, PLC

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www.vanellachiro.com
757-270-1333

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean:

Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of Disease.

A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Enzyme, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, Mineral, Trace Element, Enzyme, Amino Acid, Herb, or Homeopathic Remedy may have an effect on the disease process of symptoms, this does not mean that it can be misrepresented or classified as a DRUG by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patients diet in order to supply good nutritional support o the physiological biomechanical process of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the V.S.C. (Vertebral Subluxation Complex).

Please acknowledge by signing below that you have read the aforementioned and understand that any nutritional recommendations given you by this office are nutritional recommendations and dietary suggestions, and are not for the treatment or cure for any disease process that you may possess.

Patient Signature

Print Name

Date

Staff Signature