

VANELLA CHIROPRACTIC

"Helping families get well and stay well for a lifetime."

Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F										
DOB:	AGE:	Height:	Weight:								
Marital Status:	# of Children:	Occupation:									
Address	Zip code:										
Email:	Cell Phone:										
How did you hear about us?											
Who is your primary care physician?											
Date and reason for your last doctor visit?											
Are you also receiving care from any other health professionals? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If yes, please name them and speciality: _____											
Please note any significant family medical history:											
INSURANCE (fill out only if the insurance is not in your name)											
Guarantor's Name:		DOB:									
Relation to you:											
CURRENT HEALTH CONDITIONS											
What health condition(s) bring you to our office:											

Have you received care for this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If yes, please explain: _____											
How would you rate your pain on a scale of 1 - 10 (circle one)											
Mild	1	2	3	4	5	6	7	8	9	10	Severe
When did the condition(s) first begin?											
How did the problem start? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually <input type="checkbox"/> Post injury											
Is this condition <input type="checkbox"/> Getting worse <input type="checkbox"/> Improving <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Unsure											
What makes the problem better?											
What makes the problem worse?											
YOUR HEALTH GOALS											
Your top three health goals											
1											
2											
3											
CHIROPRACTIC HISTORY											
What would you like to gain from chiropractic care?											
<input type="checkbox"/> Resolve existing condition <input type="checkbox"/> Overall wellness <input type="checkbox"/> Both											
Have you ever visited a chiropractor? <input type="checkbox"/> No <input type="checkbox"/> Yes, what is their name?											
What is their specialty? <input type="checkbox"/> Pain relief <input type="checkbox"/> Physical therapy & rehab <input type="checkbox"/> Nutritional <input type="checkbox"/> Subluxation <input type="checkbox"/> Other											
Do you have any health concerns for other family members today?											

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? Yes No
If yes, please explain:

Notable childhood injuries? No Yes, please explain:

Youth or college sports? No Yes, please explain:

Any auto accidents? No Yes, please explain:

Exercise frequency? None 1-2x per week 3-5x per week Daily

What types of exercise?

How do you normally sleep? Back Side Stomach

Do you wake up: Refreshed and ready Stiff and tired

Do you commute to work? No Yes, how many minutes per day?

List any problems with flexibility? (ex. putting on shoes/socks)

How many hours per day do you typically spend sitting at a desk or computer, table, phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	<i>None</i>					<i>High</i>					
	1	2	3	4	5	1	2	3	4	5	
Alcohol	1	2	3	4	5	Processed foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs/other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	<i>None</i>					<i>High</i>					
	1	2	3	4	5	1	2	3	4	5	
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

HEALTH: Now & Future

1. On the left scale, mark where you believe your level of health & wellness is at this time.
2. On the right scale, mark where you would like your health & wellness to be.
3. On the bottom, mark how long you think it will take to achieve your goal.

	Excellent 95 - 100	
	Very Good 90 - 94	
	Good 80 - 89	
	Transition 70 - 79	
	Challenged 60 - 69	
	Poor 0 - 59	

How long: _____ days - weeks - months - years

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio-therapy, diagnostic thermography, surface emg, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I

Patient Signature

Date

Do not write in this box. For doctor's use only.

New patient health objectives

- Temporary symptom relief only
 Health Maintenance

- Symptom relief plus correction for prevention of recurrence
 Health Development

FINANCIAL 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.

Patient Signature

Date

HIPAA Consent

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.

Special cases

- To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
- In fundraising and marketing 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.

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.

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.

Patient Signature

Date

Vanella Chiropractic 4661 Haygood Rd. #110 Virginia Beach, VA 23455 757-270-1333

LAST PAGE