VANELLA CHIROPRACTIC

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

Name			Sex: □ M □ F
DOB:	AGE:	Height:	Weight:
Marital Status:		# of Children:	Occupation:
Address			
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?			□ Yes □ 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? □ Yes □ 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? □ Suddenly □ Gradually □ Post injury

Is this condition □ Getting worse □ Improving □ Intermittent □ Constant □ 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?

□ Resolve existing condition □ Overall wellness □ Both

Have you ever visited a chiropractor? □ No □ Yes, what is their name?

What is their specialty? □ Pain relief □ Physical therapy & rehab □ Nutritional □ Subluxation □ 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:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	1	2	3	4	5	Processed foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial sweetners	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:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
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

TYPES OF NERVOUS SYSTEMS

Please write 1 for past and 2 for present for each symptoms you have experienced in the last 6 months.

BALANCED NERVOUS SYSTEM

_________ High Energy
_________ Resistance to infections
_________ Mentally Alert
_________ Active
_________ No Symptoms
_________ Positive Mental Attitude
_________ Excellent health
_________ Vibrant

UNDER-AROUSED NERVOUS SYSTEM

_________ Poor attention
_________ Easily distracted
_________ Depressed
_________ Poor concentration
_________ Constipation
_________ Difficulty Waking
_________ Irritable
_________ Impulsive
_________ Disorganized
_________ Lacking motivation
_________ Spaciness
_________ Low pain threshold
_________ Worry
_________ Low energy

OVER-AROUSED NERVOUS SYSTEM

_________ Pain
_________ Tight muscles
_________ Anxiety
_________ Restless Sleep
_________ Poor immune system
_________ High blood pressure
_________ Irritable bowel
_________ Acid reflux
_________ Teeth grinding
_________ Allergies & eczema
_________ Diarrhea
_________ Cold hands
_________ Cold feet
_________ Heart palpitations
_________ Poor expression of emotions
_________ Racing mind
_________ Accelerated aging
_________ Indigestion/heartburn
_________ Insomnia
_________ Infertility/Impotence
_________ Bladder & urination issues
_________ Cramps & menstrual issues

UNSTABLE NERVOUS SYSTEM

_________ Migraines
_________ Seizures
_________ Sleepwalking
_________ PMS
_________ Bed Wetting
_________ Bi-polar disorders
_________ Mood swings
_________ ADHD
_________ Autism
_________ Headaches
_________ Sciatica & radiating pain
_________ Hot flashes
_________ Food Sensitivities
_________ Eating disorders
_________ Schizophrenia
_________ Panic attacks
_________ Aspergers
_________ Sensory Processing Disorders

EXHAUSTED NERVOUS SYSTEM

_________ Cancer
_________ Diabetes
_________ Depression
_________ Fibromyalgia
_________ Epstein Barr Syndrome
_________ Rheumatoid arthritis
_________ Multiple Sclerosis
_________ Chronic fatigue syndrome
_________ ALS
_________ Parkinsons

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 __________

TURN PAGE

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**
- ☐ **Symptom relief plus correction for prevention of recurrence**
- ☐ **Health Maintenance**
- ☐ **Health Development**