VITALITY CHIROPRACTIC AND MEDICAL WELLNESS
VIBRANT FOR LIFE

NEW PATIENT HEALTH HISTORY FORM

In order to provide you with the best possible care, please complete this form and bring it in to your first appointment. All information is strictly **CONFIDENTIAL**.

First name:	**Last name:**	**Date:**
Email address:		
Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions		

MAILING ADDRESS			
Address:	City:	State:	Zip:
Phone (cell)	(home)	(work)	
Birth date:	Social Security #	Referred by:	
Occupation:	Employer:		
Marital Status:	Number of children:		
Spouse's name:	Spouse's employer:		
Emergency contact:	Phone number:		

CURRENT COMPLAINTS	
If this is an injury, State the Nature of injury: ☐ Automobile* ☐ Work ☐ Other	
Date of Injury:	Complaints:
Please Describe:	
Have you had these symptoms before? ☐ No ☐ Yes	If yes, when?
List of other practitioners seen for these symptoms:	
Have you ever been under chiropractic care? ☐ No ☐ Yes	
If yes, please describe:	

INSURANCE INFORMATION	
Name of party responsible for payment:	Phone:
Do you have health insurance? ☐ No ☐ Yes	Name of company:
Insurance company name:	Contact person:
Phone number:	Claim number:

SIGNATURES

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered To me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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MEDICAL HISTORY			
Have you been treated for any conditions in the last year? ☐ No ☐ Yes			
If yes please describe:			
Date of last physical exam:	Is there a chance that you are pregnant? ☐ No ☐ Yes		
Have you had X-rays taken? ☐ No ☐ Yes	If yes, where?		
What medications are you taking and for what conditions (please list dosage and amounts, etc):			
What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage and frequency):			

HAVE YOU EVER:	NO	YES	BRIEFLY EXPLAIN
Broken bones?	☐	☐	
Been hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had sprains/strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

PAIN AND SYMPTOMS		
Do you experience pain every day?	☐ No	☐ Yes
Do your symptoms interfere with daily life?	☐ No	☐ Yes
Does pain wake you up at night?	☐ No	☐ Yes
Are your symptoms worse during certain times of the day?	☐ No	☐ Yes
Do changes in weather affect your symptoms?	☐ No	☐ Yes
Do you wear orthotics?	☐ No	☐ Yes
What activities aggravate your symptoms?		

FAMILY HISTORY
Family members- Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc):

HABITS	NEVER	RARELY	SOMETIMES	OFTEN
Drink alcohol	☐	☐	☐	☐
Drink coffee	☐	☐	☐	☐
Use tobacco	☐	☐	☐	☐
Use drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Have an appetite	☐	☐	☐	☐
Drink soft drinks	☐	☐	☐	☐
Drink water	☐	☐	☐	☐
Eat salty/sugary foods	☐	☐	☐	☐
Eat artificial foods	☐	☐	☐	☐
Use sweeteners	☐	☐	☐	☐

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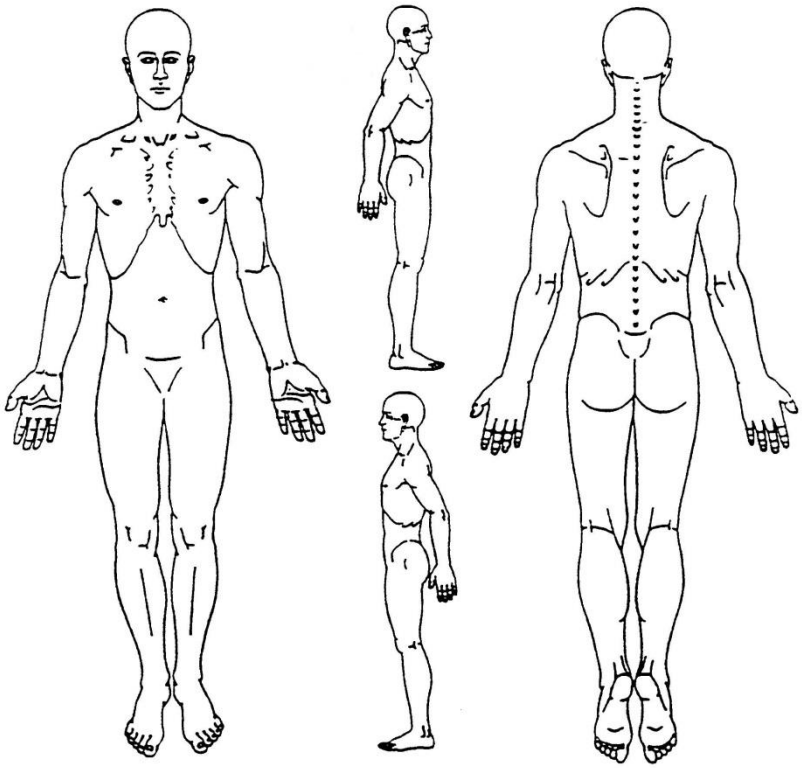
HAVE YOU EVER SUFFERED FROM:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ringing
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lumps in Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

Please use the following letters to indicate the type and location of the symptoms you are currently experiencing.

A = Ache	O = Other
B = Burning	P = Pins & Needles
N = Numbness	S = Stabbing



Vitality Chiropractic and Medical Wellness

Providing comprehensive health care since 1982

Dr. Diego Proano, D.C.

Chiropractor

Owner

Clinical Director

Consent for Examination

I hereby authorize Vitality Chiropractic and Medical Wellness and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the practice doctors to make these decisions about my care, based on the facts then known, that they believe are in my best interest.

Insurance Assignment of Benefits

I assign payment by my insurance company directly to Vitality Chiropractic and Medical Wellness. I understand that I am financially responsible for charges and copayments not covered by my insurance carrier. In the unfortunate event collection procedures are required to collect an outstanding balance, the patient shall be responsible for all reasonable cost of a collection agency, attorney, and/or court costs.

Release of Information

I authorize the use and disclosure of health information that pertains to me for treatment, payment, or official operations. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. In addition, I authorize Vitality Chiropractic and Medical Wellness to share findings/send reports to my family physician or other health care provider listed on my health history form.

I understand that I may revoke this authorization at any time by signing the revocation of my copy of this form and returning it to Vitality Chiropractic and Medical Wellness. I further understand that any such revocation does not apply to the extent that persons authorized to use to disclose my health information have already acted in reliance on this authorization.

I understand this authorization will automatically expire at the end of my treatment cycle. I understand that I have the right to inspect and obtain a copy of any information disclosed pursuant to this authorization. I understand that Vitality Chiropractic and Medical Wellness will receive compensation for the uses and disclosures that I have authorized.

I authorize Vitality Chiropractic and Medical Wellness to leave any messages necessary at my home/work in regards to any appointments, billing, or insurance issues that may occur.

_____

Patient Printed Name Patient Signature Date

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_____

Patient Signature (Patient or Legal Representative for Patient)

_____ _____

Printed Name Date

_____

Legal Representative's Relationship to Patient

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Consent for Treatment

Dr. Diego Proano, D.C.

Chiropractor

Owner

Clinical Director

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction. Based on current findings, practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. The doctors have answered my questions regarding the planned treatment and course of care that I will receive.

I have also been advised that although the incidence of complications associated with chiropractic services is extremely rare, anyone undergoing adjusting or manipulative procedures should know that rare possible hazards and complications that may be encountered or result during the course of care. These include but are not limited to fractures, disc injuries, strokes, dislocations, sprains and those which relate to physical aberrations unknown or undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the practice doctors will advise me of any material risks in the regard.

2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based on the facts known to the doctor during my course of care.

3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, or an undesirable result does not necessarily indicate any error in judgment or treatment. In addition, there is no guarantee as to results with respect to any course of care or treatment.

I have read this consent and have had an opportunity to ask questions about the consent and understand the care and treatment I may receive. My signature below acknowledges my consent to evaluation and treatment by the practice.

_____

Patient Printed Name Patient Signature Date

_____

Doctor Printed Name Doctor Signature Date