New Patient Intake

First Name:___________________________Middle Initial:___ Last Name:_______________________________________

Home Phone #:______________________Cell Phone #:______________________Work Phone #:___________________

Address:____City: ________________________________

State:_______Zip:________________ E-mail Address:____

Age:____DOB:____________________□ Male □ Female Race:_______ Height:__________Weight: ______________

Primary Care Physician Name:________________________Physician Phone Number: ______________________________

Occupation:______________________________Employer: ____

Average # Hours per Week Currently Worked:______________Are you currently working? □ YES □ NO

Full duty/Light Duty Restrictions: ____

Type of Tasks Performed/Common Movements: ____

Were you limited in your ability to perform your job duties? □ Yes □ No

If yes, please provide details:____

Do your work activities mostly involve: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Have you missed work or school due to your injuries? □ Yes □ No If yes, how many days? ____________________

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor

Emergency Contact Name:_______________________Relation: ___________________Phone #:__________________

I give Permission to Vida Chiropractic to call/text/email/leave messages regarding my appointments: Yes □ No □

INJURY INFORMATION

Date of Injury:_____________Nature of Injury: □ Car Accident □ Slip and Fall □ Other: ___________________________

Have you had an auto accident? (X if applies): □ 0-6mo □ 6 mo-1 yr □ 1-3yrs □ 3+yrs □ Never

Had a recent fall/other accident? (X if applies): □ 0-6mo □ 6 mo-1 yr □ 1-3yrs □ 3+yrs □ Never

Have You Ever Received Chiropractic Care? □ Yes □ No Last Visit? _________________________

Do you have auto insurance? □ Yes □ No Name of Carrier: _________________________________

Policy #: ___________________________ Claim #: ____

Do you have health insurance? □ Yes □ No Name of Carrier: ________________________________

Do you have secondary insurance? □ Yes □ No Name of Carrier: ________________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF ALL OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with_____________________________________and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, **VIDA CHIROPRACTIC**, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME and any causes of action I may have against my insurance provider for any dispute of Insurance payments. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Signature:____Date: _________________

Patient Name:____Date: __________________

Areas of WORST discomfort. Please complete questions for EACH area of complaint.
Please ask the front desk for additional pages if more than three main areas of complaint.

Complaint #1 ______________________________

Type of pain in this area: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Tight ☐ Pressure

How much of your day is spent in pain? ☐ Constant ☐ Frequent ☐ Intermittent (comes and goes) ☐ Occasional

Current Pain Intensity (check): ☐ NONE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ SEVERE

What makes this pain worse? ☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Twisting ☐ Lifting ☐ Activity ☐ Sleeping

Other: ____

What makes this pain better? ☐ Rest ☐ Ice ☐ Heat ☐ Therapies ☐ Stretching ☐ TENS unit ☐ Medications ☐ Brace

Other: ____

Does pain radiate into your (check):

☐ L ☐ R: ☐ Shoulder ☐ Arm ☐ Hand ☐ L ☐ R: ☐ Buttock ☐ Leg ☐ Foot ☐ Pain does not radiate

Do you have numbness and/or tingling? (check):

☐ L ☐ R: ☐ Shoulder ☐ Arm ☐ Hand ☐ L ☐ R: ☐ Buttock ☐ Leg ☐ Foot ☐ N/A

Complaint #2 ______________________________

Type of pain in this area: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Tight ☐ Pressure

How much of your day is spent in pain? ☐ Constant ☐ Frequent ☐ Intermittent (comes and goes) ☐ Occasional

Current Pain Intensity (check): ☐ NONE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ SEVERE

What makes this pain worse? ☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Twisting ☐ Lifting ☐ Activity ☐ Sleeping

Other: ____

What makes this pain better? ☐ Rest ☐ Ice ☐ Heat ☐ Therapies ☐ Stretching ☐ TENS unit ☐ Medications ☐ Brace

Other: ____

Does pain radiate into your (check):

☐ L ☐ R: ☐ Shoulder ☐ Arm ☐ Hand ☐ L ☐ R: ☐ Buttock ☐ Leg ☐ Foot ☐ Pain does not radiate

Do you have numbness and/or tingling? (check):

☐ L ☐ R: ☐ Shoulder ☐ Arm ☐ Hand ☐ L ☐ R: ☐ Buttock ☐ Leg ☐ Foot ☐ N/A

Complaint #3 ______________________________

Type of pain in this area: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Tight ☐ Pressure

How much of your day is spent in pain? ☐ Constant ☐ Frequent ☐ Intermittent (comes and goes) ☐ Occasional

Current Pain Intensity (check): ☐ NONE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ SEVERE

What makes this pain worse? ☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Twisting ☐ Lifting ☐ Activity ☐ Sleeping

Other: ____

What makes this pain better? ☐ Rest ☐ Ice ☐ Heat ☐ Therapies ☐ Stretching ☐ TENS unit ☐ Medications ☐ Brace

Other: ____

Does pain radiate into your (check):

☐ L ☐ R: ☐ Shoulder ☐ Arm ☐ Hand ☐ L ☐ R: ☐ Buttock ☐ Leg ☐ Foot ☐ Pain does not radiate

Do you have numbness and/or tingling? (check):

☐ L ☐ R: ☐ Shoulder ☐ Arm ☐ Hand ☐ L ☐ R: ☐ Buttock ☐ Leg ☐ Foot ☐ N/A

List any OTHER symptoms have you are experiencing that are not covered by the questions above:

____
____
____
____

PATIENT HEALTH HISTORY:

Please **circle:** currently **C** and/or past **P** to indicate if you are experiencing any of the following conditions.

P/C Neck Pain/Stiffness
P/C Back Pain/Stiffness
P/C Arm/Hand Pain
P/C Leg/Knee Pain
P/C Headaches
P/C Night Pain
P/C Depression
P/C Cold Extremities
P/C Nervousness
P/C Sleeping Difficulties
P/C Pins/Needles in Arms
P/C Pins/Needles in Legs
P/C Light Bothers Eyes
P/C Recent Weigh Change
P/C Loss of Memory
P/C Nausea
P/C Loss of Taste
P/C Fatigue
P/C Chest Pain
P/C Tension
P/C Jaw Problems
P/C Loss of Smell
P/C Fainting
P/C Dizziness
P/C Stomach Problems
P/C Asthma
P/C Swollen Joints
P/C Mood Changes
P/C Foot Trouble
P/C Fever
P/C Cold Sweats
P/C Constipation/Diarrhea
P/C Allergies
P/C Shortness of Breath
P/C Blurred/Double Vision
P/C Bowel/Bladder Changes
P/C Trouble Concentrating
P/C Loss of Balance

Please check if you have ever had any of the following:

□ ADD/ADHD
□ Aids/HIV
□ Alcoholism
□ Allergy Shots
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Colon Trouble
□ Contacts/Glasses
□ Diabetes
□ Dry Skin
□ Ear Infections
□ Epilepsy
□ Fractures
□ Gall Bladder
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Bronchitis
□ Bulimia
□ Gout
□ Heartburn
□ Heart Attack
□ Heart Problems
□ Hemorrhoids
□ Hepatitis
□ Hernia
□ Herniated Disc
□ High/Low Blood Pressure
□ High Cholesterol
□ Hormone/Gland Problems
□ Insomnia
□ Kidney Problems
□ Anorexia
□ Appendicitis
□ Asthma/Wheezing
□ Bad Breath/Bad Taste
□ Bleeding Disorders
□ Liver Disease
□ Measles
□ Menopausal Prob.
□ Migraines
□ Miscarriage
□ Mouth Sores/Bleeding Gums
□ Multiple Sclerosis
□ Nosebleeds
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Tremors
□ Ulcers
□ Breast Lump
□ Broken Bones
□ Pinched Nerve
□ Pneumonia
□ Polio
□ Prostate Problems
□ Prosthesis
□ Psychiatric Care
□ Rheumatoid Arthritis
□ Rheumatic Fever
□ Scarlet Fever
□ Sexual Difficulty
□ Stroke
□ Suicide Attempt
□ TMJ Pain
□ Tonsillitis
□ Thyroid Problems
□ Tumors/Growths
Other: ____________________

PREVIOUS ACCIDENT HISTORY:

Have you ever been involved in another motor vehicle accident or Slip and Fall? □Yes□ No

If yes, please describe and give dates: ____

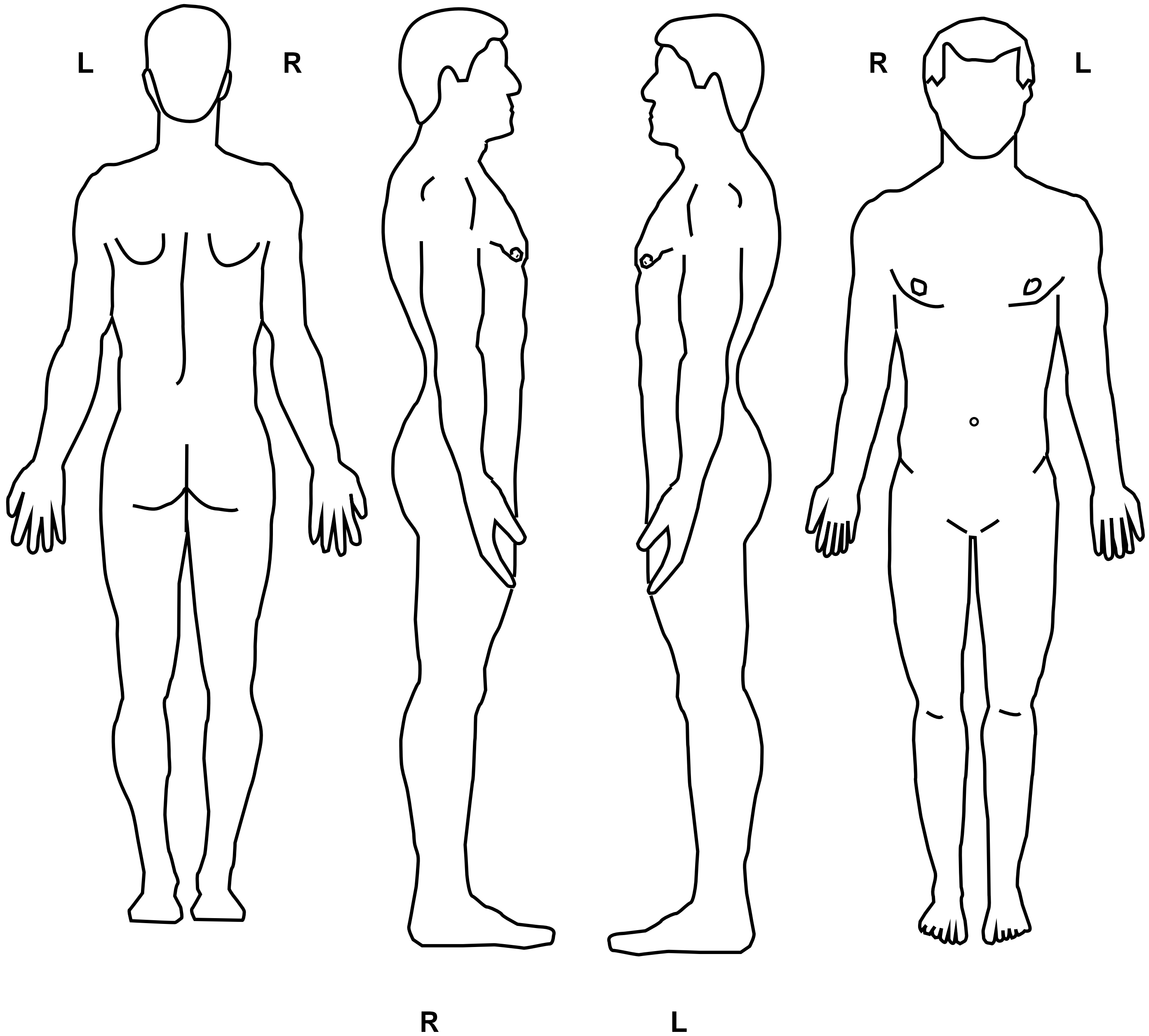
____

____

Were any MRI's taken? □ Yes □ No If yes, please list: ______________________________

PAIN DRAWING

Name ____ Date ____________



Mark as follows:

A - Ache   B - Burning   N - Numbness   P - Pins & Needles   S - Stabbing

O - Other - Describe ____

MEDICAL HISTORY CONT.

***ALLERGIES*:** (list all including medications, food, solutions & metals)

Allergen Name	Type of Reaction
1.	
2.	
3.	
4.	

SURGERIES: Please list **all** you have had: **if you are providing your own list, circle: SEE SURGERY LIST

Type	Date	Reason
1.		
2.		
3.		
4.		

CURRENT MEDICATIONS *** if you are providing your own list, circle here: SEE MED LIST

Medication Name	Dose	What is the medication for?
1.		
2.		
3.		
4.		

FAMILY HISTORY *write relationship (i.e. father) of any blood relative who has had any of the following:

Cancer	Diabetes	Epilepsy
Heart Disease	High BP	Psoriasis
Congenital Prob.	Obesity	Asthma
Alcoholism	TB	Thyroid Prob.
Rheumatic Fever	Rheumatoid Arthritis	Stroke
Other:		

Clinic Use Only Provider Notes:

____

____

____

____

Reviewed by:____ Date:________________________

TERMS AND ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, active/ passive rehabilitation, diagnostic imaging and/or chiropractic care, and/or orthopedic medicine. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. Through specific procedures, we reduce and/or correct physical or physiological disturbances. It may be necessary to examine an individual each time a new injury occurs and often x-rays or other diagnostic procedures are necessary to maintain the utmost safety when dealing with your body. The risks of orthopedic, physical medicine, diagnostic imaging and chiropractic medicine are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

I have read and fully understand the above terms of acceptance. I hereby give my consent to evaluate me and determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or treatment if I so choose.

I,_________________________________have read and fully understand the above statements.
(Patient Name - PRINT)

Patient Signature:____Date: ___________________

FOR MINORS:

I,________________________, being the parent or legal guardian of________________________,
(print guardian's name) **(minor's name)**
have read and fully understand the above terms of acceptance and hereby grant permission to Vida Chiropractic for my child to be evaluated, the condition determined and to receive treatment for such conditions. I also understand that I may at any time discontinue with the exam and/or treatment if I so choose.

I wish to be physically present for all treatment rendered to my minor child (circle): YES NO

Parent/Guardian Signature:____Date: ___________________

Patient Name:**________________________________**

NOTICE OF PRIVACY PRACTICES:

Vida Chiropractic, (VC) is required by law to maintain the privacy of your protected health information. The Notice of Privacy Practices tells you how your protected health information may be used and how VC keeps your information private and confidential. This notice explains the legal duties and practices relating to you protected health information. As a part of VC's legal duties this Notice of Privacy Practices must be given to you upon your request. VC is required to follow the terms of the Notice of Privacy Practices currently in effect. VC may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on VC Centers and will be available by email upon request.

Uses and Disclosures of your protected Health Information

Protected health information includes demographics and medical information that concerns the past, present, and/or future physical or mental health of an individual. Demographics information could include our name, address, phone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. VC can act as each of the above business type. This medical information is used by VC in many ways while performing normal business activities. Your protected health information may be used or disclosed by VC for purposes of treatment, payment and health care operations.

Healthcare professionals use medical information in the clinics or hospitals to take care of you. Your protected health information may be shared, with or without your consent, with another healthcare provider for purposes of your treatment. VC may use or disclose your health information with case management and services. VC may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you. Your information may be used by certain department personnel to improve VC's healthcare operations. VC also may send you appointment reminders, information about your treatment options or other health related benefits and services. Some protected health information can disclose without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Interval investigations and audits by VC's divisions, bureaus, offices.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of

Program Policy Analysis and Government Accountability.

- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulations of health professionals.
- District medical examiner investigations.
- Research approved by VC.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, judicial and administrative proceedings.

Other uses and disclosures of your protected health information by VC will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request VC to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. VC is not required to agree to any restrictions. You have the right to be assure that your information will be kept confidential. VC may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you. You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was no involved in the decision to deny access. This licensed health care professional will be designated by VC.

Signature:**________________________________** ***Date:*** **__________________________**

VIDA CHIROPRACTIC FINANCIAL POLICY

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. Our office participates in several insurance plans. Each plan has its own set of rules and regulations. Our office participates in these programs to allow you, the patient, to reduce your health care cost in this office.

Initial ________DEDUCTIBLES & CO-PAYMENTS:
By law we MUST collect your carriers designated co-payment at the time of service. Please be prepared to provide copayment or deductible fees each visit.

Initial ________MEDICARE:
We will submit to Medicare for the Medicare allowed amount. Medicare ONLY covers 80% of the adjustment cost. The patient will be responsible for the exam, therapeutic modalities, deductible, and 20% co-insurance (of the adjustment cost). We are happy to bill to your secondary insurance if you have one.

Initial ________NON-COVERED MODALITIES, XRAYS, & EXAM FEES:
In the event your policy does not cover the cost for therapeutic modalities, x-rays, and/or exam codes, you will be responsible for the cost. We cannot guarantee payment, as we are not the insurance carrier. HOWEVER, as a courtesy to you, we will confirm your coverage. It is our suggestion that you also confirm your chiropractic & physical therapy coverage to eliminate any chance for misinformation. If payment(s) from insurance are delayed more than three months, we require you to reimburse our office in full for services rendered. **The patient is liable for any and all expenses incurred in our office.*

Initial ________PATIENTS WITHOUT INSURANCE COVERAGE:
Payment is required at the time of service unless other financial arrangements have been made prior to your visit.

Initial ________THIS APPLIES TO TODAY'S VISIT AND ALL FUTURE VISITS:
Our office accepts cash, checks, and all major credit card carriers. There is a $25 service charge for all returned checks. I understand that failure to pay outstanding balances or make payment arrangements within 90 days, will be considered delinquent and subject to legal action. I agree to pay for reasonable collection and attorney fees.

Initial ________MISSED APPOINTMENT (WITHOUT CALL) FEE:
Our office asks that you give us a 24-hour notice if you need to cancel or reschedule an appointment. If you miss an appointment without calling to let us know that you won't be able to make it, we charge a $20 "no-show" fee. I understand that if I miss a scheduled appointment and did not contact the office to cancel/reschedule within 24 hours prior to that appointment, I will be responsible for the office fee of $20 per visit that I miss without informing the office.

CREDIT CARD ON FILE CONSENT:
As a convenience to you, we have the ability to save your credit or debit card in our secure network. The card number is securely stored with only the credit card type, and last 4 digits available to us to help identify with you what card we have on file. If you permit us to store your card, we can use it for any future authorized payments to your account. You will receive a receipt to your email on file at the time of payment. THIS IS NOT REQUIRED. We offer this option as a convenience to our patients for ease of checkout on future visits. DO NOT SIGN BELOW IF YOU DO NOT WISH TO KEEP A CARD ON FILE.
**So we can individualize care and alter treatment according to your progress it is agreed that we may need to settle a balance on a subsequent visit when new modalities are introduced.*

By signing below, you are agreeing to keep a credit card on file for future payments.

SIGNATURE ____________________________________ **DATE** __________________

PRINTED NAME ________________________________

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
Other___________________

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
Other______________________

3. What was your vehicle doing at the time of the accident?

❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Proceeding along ❑ Slowing down ❑ Accelerating
Other____

4. Time/Speed/Damage

Time of accident__________
Your vehicle's speed: ____________mph
Their vehicle's speed: ____________mph
Damage to your vehicle
❑ Mild ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good

Who hit who/what?
❑ You hit other vehicle
❑ Other vehicle hit you
You hit...(object)
____

6. Road conditions

Road conditions at time of accident
❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑ Left Front ❑ Right Front
❑ Read-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes** ❑ ❑ **No**
Were you braced for the impact? **Yes** ❑ ❑ **No**
Did you have a seat belt on? **Yes** ❑ ❑ **No**
Did you have a shoulder harness on? **Yes** ❑ ❑ **No**

Does your vehicle have headrests? Yes ❑ ❑ **No**
What was the position of your headrest at the time of the impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of the impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes** ❑ ❑ **No** Did passenger side airbags deploy? **Yes** ❑ ❑ **No** Did side airbags deploy? **Yes** ❑ ❑ **No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes** ❑ ❑ **No**
If yes, describe:____
Did you lose consciousness during the injury? **Yes** ❑ ❑ **No**
If yes, for how long?_____________________________________
Your vehicle's estimated damage? __________________________
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? **Yes** ❑ ❑ **No**
Was an accident report filled out? **Yes** ❑ ❑ **No**

10. After the accident:

Check off your symptoms right after and a few days following:
❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands
❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet
❑ Neck stiffnes ❑ Confusion ❑ Nervousness ❑ Diarrhea
❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression
❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious
❑ Loss of smell ❑ Irritability ❑ Constipation ❑ Chest Pain
❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems
Others:____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor
How did you get there?
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police
Were X-rays done? Yes ❑ ❑ No **Was lab work done?** Yes ❑ ❑ No
Body parts X-rayed?_______________________________________
What lab work?____
The X-rays revealed:_______________________________________
Treatments: ❑ Cervical Collar ❑ Ice **Other:**_______________
Medications:____
Follow-up instructions:_____________________________________
____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr.________________________ First visit date: ____/____/____
Specialty:_____________________ X-rays done? **Yes** ❑ ❑ **No**
Types of treatments received:____________________________
How many treatments received? ____ Currently treating? **Yes** ❑ ❑ **No**
Did treatments benefit you? **Yes** ❑ ❑ **No**
Last visit date: ____/____/____
2. Dr.________________________ First visit date: ____/____/____
Types of treatments received:____________________________
How many treatments received? ____ Currently treating: **Yes** ❑ ❑ **No**
Did treatments benefit you? **Yes** ❑ ❑ **No**
Last visit date: ____/____/____

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Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing .... ___ Drying hair .... ___ Brushing teeth ..... ___ Putting on shoes ..... ___ Preparing meals ..... ___ Taking out trash .. ___
Showering ...... ___ Combing hair .... ___ Making bed .... ___ Tying shoes .... ___ Eating .... ___ Doing laundry ..... ___
Washing hair .. ___ Washing face .... ___ Putting on shirt .... ___ Putting on pants ...... ___ Cleaning dishes ..... ___ Going to toilet ..... ___

Difficulties with Physical Activities

Standing .... ___ Walking .... ___ Kneeling .... ___ Bending back .... ___ Twisting left .... ___ Leaning back ...... ___
Sitting .... ___ Stooping .... ___ Reaching .... ___ Bending left .... ___ Twisting right .... ___ Leaning left .... ___
Reclining .... ___ Squatting .... ___ Bending forward .. ___ Bending right .... ___ Leaning forward ..... ___ Leaning right ...... ___
Standing for long periods .... ___ Sitting for long periods....... ___ Walking for long periods....... ___ Kneeling for long periods ..... ___

Difficulties with Functional Activities

Carrying small objects .... ___ Lifting weights off floor .... ___ Pushing things while seated .... ___ Exercising upper body .... ___
Carrying large objects .... ___ Lifting weights off table .... ___ Pushing things while standing .. ___ Exercising lower body .... ___
Carrying brief case .... ___ Climbing stairs .... ___ Pulling things while seated .... ___ Exercising arms .... ___
Carrying large purse .... ___ Climbing inclines .... ___ Pulling things while standing .... ___ Exercising legs .... ___

Difficulties with Social and Recreational Activities

Bowling .... ___ Jogging .... ___ Swimming .... ___ Ice Skating .... ___ Competitive Sports . ___ Dating .... ___
Golfing .... ___ Dancing .... ___ Skiing .... ___ Roller Skating .... ___ Hobbies .... ___ Dining out .... ___

Difficulties with Travelling

Driving a motor vehicle .... ___ Riding as a passenger in a motor vehicle ...... ___ Riding as a passenger on a train .... ___
Driving for long periods of time .... ___ Riding as a passenger on an airplane .... ___ Riding as a passenger for long periods .... ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating....____ Hearing....____ Listening....____ Speaking....____ Reading....____ Writing....____ Using a keyboard....____

Difficulties with the Senses

Seeing.........____ Hearing.........____ Sense of touch.........____ Sense of taste.........____ Sense of smell.........____

Difficulties with Hand Functions

Grasping.........____ Holding.........____ Pinching.........____ Percussive movements.........____ Sensory discrimination.........____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep.........____ Being able to participate in desired sexual activity.........____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but have not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ❑ My history HAS contributed to my current symptoms.
- ❑ My history HAS NOT contributed to my current symptoms.
- ❑ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (**if applicable**) occured........._____ ❑ months ago / ❑ years ago **Or on** Date: _____/_____/_____

Write in below any other Prior Symptom History, not covered above:

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ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and/or my attorney to pay directly to VIDA CHIROPRACTIC INC ("Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills due Assignee, and to withhold such sums from any disability benefits, medical payments, No-Fault benefits, or any other insurance benefits obligated as reimbursement from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event I do not have insurance coverage, I understand I remain personally responsible for payment of services rendered. I further give an irrevocable lien to said assignee gains any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, refuses to make such payment, upon such cause of action, that I might have or that might exist in my favor against such company, authorize Assignee to prosecute said cause of action either in my name or Assignee's and further authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

Direction of Payment

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or future bills for services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. This assignment also allows Assignee to endorse any check or draft paid to Assignee in my name for purposes of payment for services rendered to me by Assignee or its employees, or contractors or agents.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested information, which is pertinent to my case, to my insurance company or the attorney Involved in this case, pursuant to 627.4137 Florida Statutes. I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provide, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or "act- aside," the amount reduced or denied until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payments as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount reduced, or failed to pay, please notify me (the assignor) and this health care provider (the assignee).

Patients Name and Date

Signature ___________________________________

Print Name _________________________________

Date ______________________________________

Health Care Provider

VIDA CHIROPRACTIC INC

8960 SW Highway 200
Suite 5
Ocala, Fl 34481

STANDARD DISCLOSURE AND ACKNOWLEDGEMENT FORM
PERSONAL INJURY PROTECTION – INITIAL TREATMENT OR SERVICE PROVIDED

The undersigned insured person (or guardian of such person) affirms: ___________________________________

I have the right and the **duty to confirm** that the services have already been provided. I was **not solicited** by any person to seek any services from the medical provider of the services above. This means that no person has initiated contract with me and/or persuaded me to use the doctor or licensed professional, clinic or medical institution that provided the services. The medical provider has **explained** the services to me for which payment is being claimed. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also;

I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

I have **explained** the services rendered to the insured group, or his or her guardian, **sufficiently** for that person to sign this for with informed consent.

The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately** and in a **substantially complete** manner.

The coding procedures on the accompanying statement or bill are proper. This means that **no service has been up coded, unbundled** or constitutes an invalid or **no medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736 (5)(b) 6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

___________________________	______________________________	___________________
Name (Print)	Signature	Date

Licensed Medical Professional Rendering Treatment (Signature by his/her **own hand**):

Andres Leon Tax Id: 46-2212818	______________________________	___________________
Name	Signature	Date

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of Claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statues.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

8960 SW Hwy 200 Suite #5, Ocala FL 34481 Phone: 352-861-8432 Fax: 352-559-0485

MEDICAL REPORTS AND DOCTOR'S LIEN

TO: Andres Leon DC
Vida Chiropractic
8960 SW Hwy 200 Suite #5
Ocala, FL 34481

I, ____ do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Dated: _________________________ Patient's Signature: ___________________________

AUTHORIZATION TO RELEASE INFORMATION/RECORDS

I, ____ ____________________________

Print Name Clearly Date of Birth

Request my records from the providers listed below:

(Please list all healthcare providers you wish for us to request medical records/x-rays/MRIs from)

1) _________________________________ Fax_________________Phone ______________
2) _________________________________ Fax_________________Phone ______________
3) _________________________________ Fax_________________Phone ______________
4) _________________________________ Fax_________________Phone ______________
5) _________________________________ Fax_________________Phone ______________

to release my medical records including diagnosis, prognosis, initial treatment, x-rays and reports to: **DR. ANDRES F. LEON, D.C.** and **VIDA CHIROPRACTIC, INC.** I will be responsible for incurring the costs associated with this request if known in advanced. Thank you for your prompt attention.

____ ______________________________

Patient Signature (or parent if patient is a minor) Date

VIDA CHIROPRACTIC, INC.
8960 SW SR 200 Suite 5
Ocala, Florida 34481
Phone: 352-861-8432
Fax: 352-559-0485
admin@vidachirofl.com

Additional Information:

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