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

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

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

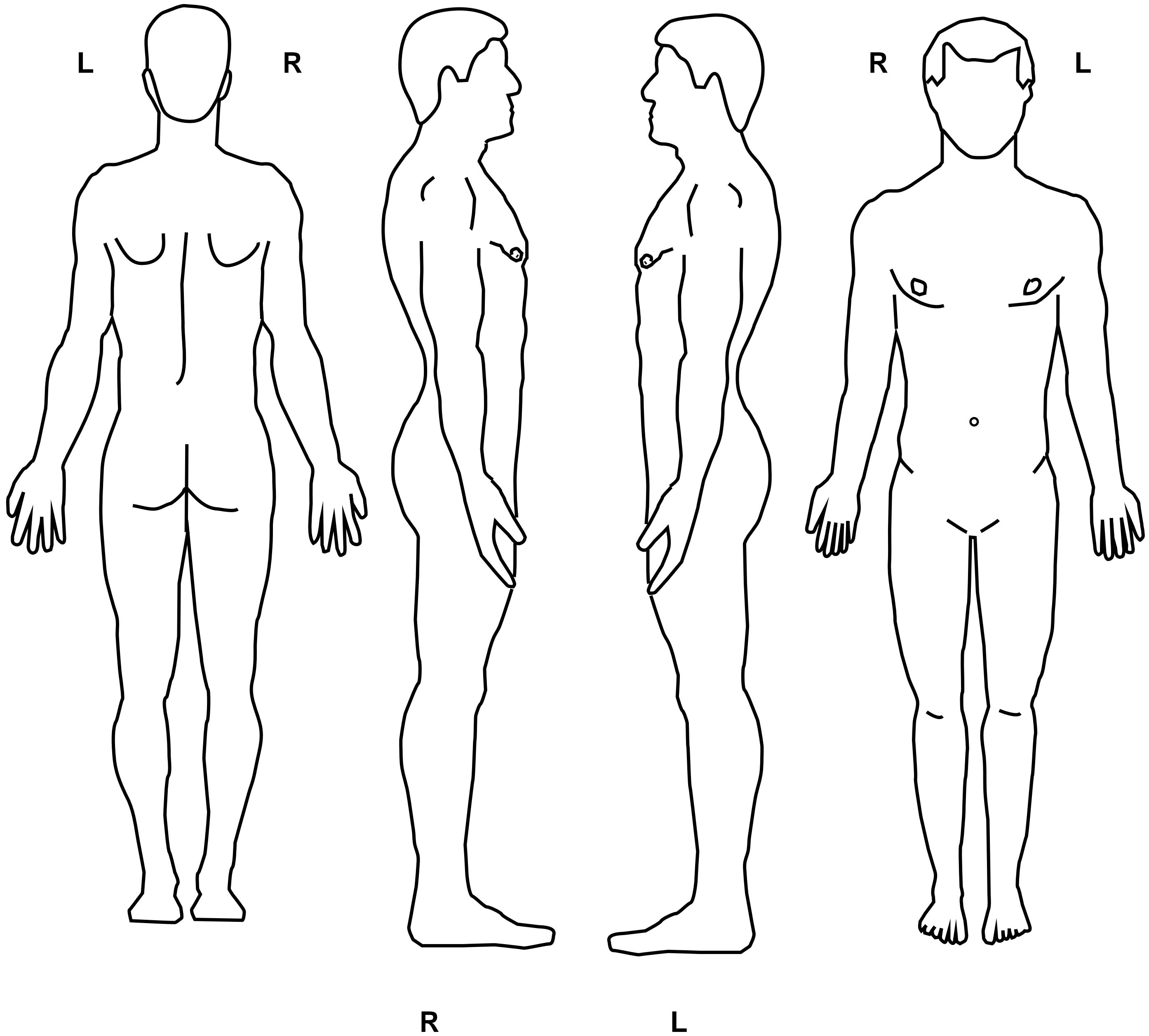
____

____

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:

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____

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 ___________________________________

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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