HEALTH SURVEY

PURPOSE: To determine if any health problems you are having may be caused by stress.

Name: ______________________ Age: ________ DOB: ____________

Email: ______________________

Phone: (Home) ____________ (Work) ____________ (Cell) ____________

Address ______________________

City ____________ State ________ Zip ________

Occupation: ______________________ # of hours: ________

I. Circle the number of any of the following symptoms you have experienced in the last 6 months.

1. Low Back Pain
2. Neck Pain
3. Pain between Shoulder blades
4. Tension/Headaches
5. Tired or Fatigued
6. Wrist/Hand Pain
7. Elbow Pain
8. Shoulder Pain
9. Hip Pain
10. Knee Pain
11. Ankle/Foot Pain
12. Ringing in ears
13. Allergies
14. Digestive Problems
15. Weight Trouble
16. Tension across the Top of Shoulders
17. Tingling/Numbing in Arms or Hands
18. Tingling/Numbing in Legs or Feet
19. Dizziness
20. Nervousness
21. Difficulty Sleeping

Which one of the above symptoms is worst? ______________ How long have you had it? ________

When is it at its worst, how do you feel? ______________________

II. How this causes you to act?

1. Moody 2. Irritable 3. Interrupts Sleep 4. Restricted on daily activities 5. Other: ____________

III. How this affects you at work?

1. Decision making 2. Exhausted at End of Day 3. Decreased Productivity

4. Poor Attitude 5. Unable to work long hours 6. Other: ____________

IV. How does this affect your home life?

1. Lose patience with spouse/children 2. Hinders ability to exercise or participate in sports

3. Restricted household duties 4. Interferes in abilities to participate in hobbies/other desires activities

If you circled any of the above items you could be suffering from EXCESSIVE STRESS, STRUCTURAL MISALIGNMENT OR PINCHED NERVES. Chiropractic Doctors treat the body gently, naturally & without drugs to remove your stress & imbalances that CAUSE health problems. **WOULD YOU LIKE TO FIX THIS PROBLEM? YES_____ NO_____**

If you answered YES there are several alternatives available to you. Please circle the item most appropriate to you.

1. I would like to come to the Doctor's office for a complete evaluation. There is NO CHARGE for the examination. This will allow me to find out if I can be helped by Chiropractic without any financial barriers.
2. I would like to come to a class on STRESS & WELLNESS.
3. I would like the Doctor to call me & discuss my health problems before making an appointment.

Do you have insurance? YES_____ NO_____ PPO? YES_____ NO_____

VITALITY HEALTH CENTER

318 Lincoln Boulevard, #225
Venice, CA 90291

Office: 310.396.3635
Fax 310.396.3645

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapy techniques, on me (or on the patient name below, for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/ or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for , or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are certain complications which may arise during a chiropractic adjustment, as with any health care procedure. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain/sprain and separations. Some types of manipulation of the neck have been associated with injuries to the arteries, leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at this time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the result(s) of said treatment(s) is/are not guaranteed.

I have read (   ), or have read to me (   ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have I myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to said treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name: ______________________________ Signature of Patient: ______________________________

Date Signed: __________________ Witness to Patient's Signature: ______________________________

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS AMINOR OR PHYSICALLY OR LEGALY INCAPACITATED

Patient Name: ______________________________ Name Of Representative: ______________________________

Date Signed: __________________ Signature of Representative: ______________________________

Relationship or Authority of Patients Representative: ______________________________

Translated By: ______________________________ Date: __________________

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office: **The Vitality Health Center**

Address: 318 So. Lincoln Blvd. Ste. # 225 Venice, Ca. 90291
Name of Doctor's Treating This patient: Dr. Yariv Rothman, DC DC 25498

1. Yariv Rothman D.C, L.V.N, Q.M.E Pin: DC 25498
2. ______________________________ Pin: ______________________________

☐ Original to patient's file by: ______________________ ☐ Copy to patient by: ______________________

MEDICAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_______________

Patient_______________

Address_______________

____
City State Zip

Sex: ☐ M ☐ F Age______ Birthdate_______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_______________

Occupation_______________

Employer_______________

Employer Address_______________

Employer Phone_______________

Spouse's Name_______________

Birthdate_______________ SS#_______________

Occupation_______________

Spouse's Employer_______________

Whom may we thank for referring you?_______________

____

2 INSURANCE

Who is responsible for this account?_______________

Relationship to Patient_______________

Insurance Co._______________

Group #_______________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_______________

Birthdate_______________ SS#_______________

Relationship to Patient_______________

Insurance Co._______________

Group #_______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_______________ and assign directly to Dr._______________ all insurance benefits, if any, otherwise payable to me for services rendered. 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 to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

_______________ _______________
Relationship Date

3 PHONE NUMBERS

Email address:

Home_______________ Work_______________ Ext_____

Best time and place to reach you_______________

IN CASE OF EMERGENCY, CONTACT

Name_______________ Relationship_______________

Home Phone_______________ Work Phone_______________

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date__________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_______________

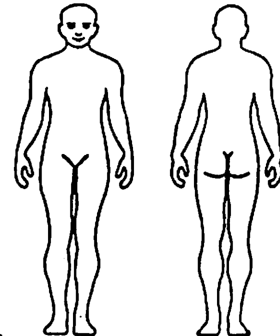
5 PATIENT CONDITION

Reason for Visit_______________

When did your symptoms appear?_______________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)__________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?_______________

Is it constant or does it come and go?_______________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other ____________

Name and address of other doctor(s) who have treated you for your condition ____________

Date of Last: Physical Exam ____________ Spinal X-Ray ____________ Blood Test ____________
Spinal Exam ____________ Chest X-Ray ____________ Urine Test ____________
Dental X-Ray ____________ MRI, CT-Scan, Bone Scan ____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other ____________	
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Measles	☐ Yes ☐ No				
Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No				

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/Day ____________
☐ Alcohol — Drinks/Week ____________
☐ Coffee/Caffeine Drinks — Cups/Day ____________
☐ High Stress Level — Reason ____________

Are you pregnant? ☐ Yes ☐ No Due Date ____________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

Pharmacy Name ____________

Pharmacy Phone ____________

ALLERGIES

VITAMINS/HERBS/MINERALS

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Medical Release / Waiver

Name: ______________________________ Date: ______________

Email: ______________________________ Male Female

Phone: (Home) ____________________ (Cell) ____________________

Please answer all that apply:

Do you exercise regularly or participate in any sports?	Yes	No
If yes, what kind: ____________________		
Have you ever had surgery?	Yes	No
If yes, please describe: ____________________		
Do you wear contact lenses?	Yes	No
Do you wear dentures?	Yes	No
Do you have any skin problems?	Yes	No
If yes, please describe: ____________________		
Do you have any allergies?	Yes	No
If yes, please describe: ____________________		
Do you take any prescribed medication?	Yes	No
If yes, please describe: ____________________		
Have you suffered an acute injury in the past year?	Yes	No
If yes, please describe: ____________________		
Do you have any spinal problems?	Yes	No
If yes, please describe: ____________________		
Are you pregnant?	Yes	No
If yes, which trimester are you currently in: ____________		

Do any of the following apply to you:

Varicose Veins	Yes	No
Arthritis	Yes	No
Blood Clots	Yes	No
Heart Problems	Yes	No
Blood Pressure Problems	Yes	No
Cancer	Yes	No
HIV+ / AIDs	Yes	No

Do you have any areas that require special attention?

____

Do you have any other medical conditions that we should be aware of before this activity?

____

I understand that the therapist/instructor does not diagnose illness, disease, or any other physical or mental disorder. As such, the therapist/instructor does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I also understand that this activity is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

My participation in this activity is voluntary and at my own risk. To the best of my knowledge, the health information above is true and accurate. I hereby release respective owners, instructors, or therapists from any liability for any claims, demands, injuries, services, equipment or facilities provided by the therapist. I have carefully read with a full, definite and clear understanding of the foregoing provisions and freely enter into the within agreement of waiver/release.

______________________________ ______________________________
Patient Signature Date

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Office Policy and Rules

Welcome to Vitality Health Center! We're grateful that you have chosen to receive your health care in our facility. To ensure quality of service, please sign and date that you have received notice of the office policies and rules.

1. **I agree to the following appointment schedule given by my doctor. I understand that I will be expected to make up any missed appointments with in seven (7) days. Failure to make up any missed appointments will result in a service charge of $35.00 and will be billed to me directly, and is not payable by insurance, lien, workers compensation, etc. If you are going to be late, please let us know with a phone call so that we may reserve your space. If you are more than 10 minutes late, we will take the next patient first.**

2. **Please make sure to confirm your appointment day and time. If you must cancel, we require 24 business hour notice. Cancellation within 24 hours notice or after business hours on the weekend will constitute a late cancellation, and we will ask that you pay a $35.00 cancellation fee to cover the practitioner's time.**

3. **I agree to follow all other recommendations made by the doctor(s), including the proper use of my spinal supports, doing my exercises as prescribed, etc. I also understand that any recommendation for future care will be made only after physical and/or x-ray examination.**

4. **I agree to make a personal financial agreement and promptly fill out all necessary medico-legal and insurance forms to aid in the timely payment for my care. If Deductable applies to my insurance benefits, I am aware that I must pay the current fee for service charge per visit.**

5. **I agree to read the HIPAA Privacy Procedures pamphlet and, in the event I do not understand my rights, ask a staff member to clarify the policies. I have also received a copy of the HIPAA privacy policies.**

6. **I understand that if my insurance company has NOT paid any claim within sixty (60) days or has denied my benefits or claim(s), as a courtesy, Vitality Health Center will resubmit necessary documentation on my behalf to support reprocessing of said claim(s). This will be done NO more than one (1) additional time, after which a copy of all unpaid claims will be provided to me. I, will be responsible to follow up on the status of payment, as well as be responsible for payment of all open/unpaid claims.**

7. **Every patient is eligible for our cash discounted fee. If you do not have insurance, have insurance that does not cover our services, or do not wish to use your insurance to cover our services, you may ask the front desk for details.**

We ask that you tell your family and friends about the wonderful services offered by Vitality Health Center. We are a family practice, and welcome all ages, bodies, and abilities! It is important that you receive the highest quality of care. If you have any suggestions or comments, please feel free to speak with any of our staff. If they cannot help you, you will be directed to someone who can.

I understand the policies of Vitality Health Center and agree to abide by them.

______________________	__________	______________________
Patient/Client signature	Date	PRINT NAME
______________________	__________	
Witness signature	Date	