

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

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 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

Email address: _____

PHONE NUMBERS

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) _____

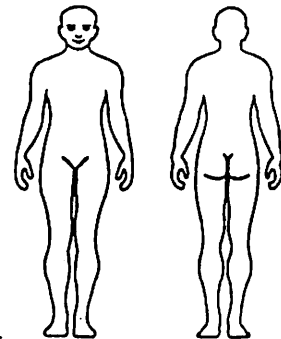
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

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

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

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



MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____
 Pharmacy Phone _____

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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 within 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 Deductible 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