MEDICAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: ____________________

Patient ____________________

Address: ____________________

____

Email: ____________________

Sex: ☐ M ☐ F Age:__________ DOB:__________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: ____________________

Employer: ____________________

Occupation ____________________

Employer Address: ____________________

Employer Phone: ____________________

Spouse's Name: ____________________

Occupation: ____________________

Whom may we thank for referring you?

____

INSURANCE

Who is responsible for this account? ____________________

Relationship to patient: ____________________

Insurance Co.: ____________________

Is patient cover by additional insurance? YES NO

Subscriber's Name: ____________________

Subscriber ID: ____________________ Group# __________

ASSIGNMENT AND RELEASE

I, the undersigned certify I (or my dependent) have insurance coverage with ____________________ and assign directly to Dr. Ronald D Zlotolow, MD and/or Dr. Yariv Rothman, DC all my 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 and for payments made directly to me. 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

PHONE NUMBERS

Primary Number: ____________________

Secondary Number: ____________________

Best time and number to reach you? ____________________

IN CASE OF EMERGENCY CONTACT

Name: ____________________

Relationship: ____________________

Primary Number: ____________________

Secondary Number: ____________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ YES ☐ NO

Date and Place of Accident: ____________________

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other:__________

To who have you made a report of your accident?

____

Attorney Name: ____________________

Phone Number: ____________________

PATIENT CONDITION

Reason for Visit: ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ☐ YES ☐ NO ☐ UNKNOWN

Mark and 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) __________

Circle type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: __________

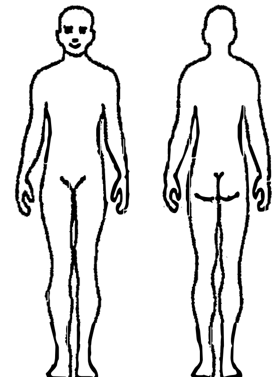
How often do you have this pain? ____________________

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:

Condition		Condition		Condition		Condition	
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	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name ____________		
Pharmacy Phone ____________		

PRIMARY PHYSICIAN INFORMATION

Practice Name (if applicable):		
Physician's Name:		
Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	
Date of Last Visit:	Date of Last Physical Exam:	
Conditions treated with this physician:		

May I send a copy of your consultation and screening to your primary care provider and consult with him/her as necessary?

☐ Yes ☐ No

____
Signature

____
Date

HEALTH SURVEY

PURPOSE: To determine if any health issues you are experiencing may be caused by stress or spinal dysfunction.

Name:____

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. Ringing in Ears
10. Allergies
11. Digestive Problems
12. Weight Trouble
13. Tension across the Top of Shoulders
14. Tingling/Numbing in Arms or Hands
15. Tingling/Numbing in Legs or Feet
16. Dizziness
17. Hip Pain
18. Knee Pain
19. Ankle / Foot Pain
20. Nervousness / Anxiety
21. Difficulty Sleeping
22. Depression
23. Problems with Fertility

Which of the above symptoms are the worst? ____________________How long have you had them? ____________

What treatments have you tried? ____

How does this affect your behavior? (circle all that apply)

1. Moody / Irritable 2. Interrupts sleep 3. Restricts daily activities 4.Other:__________________________

How this affects you at work? (circle all that apply)

1. Decision making 2. Exhausted at end of day 3. Decreased productivity

4. Poor attitude 5. Unable to work long hours 6. Other:____________________________

How does this affect your home life? (circle all that apply)

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

Vitality Health Center can help you with these problems. Would you like more information about these services we offer: (circle all that apply)

1. Acupuncture / Chinese Herbs 2. Chiropractic 3. Massage Therapy

4. Nutritional Counseling 5. Physical Therapy 6. Private Instructor Pilates

Vitality Health Center is an In-Network Provider with most PPO Insurance plans. Would you like us to see if your plan's benefits would cover our services? YES / NO

Medical Release / Waiver

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 medications?	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, in which trimester are you currently: ___________________		
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 does s/he 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, and 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 forgoing provisions and freely enter into the within agreement of waiver/release.

____ ______________________

Client Signature Date

Health Profile

NAME ______________________ DATE __________ WEEK __________

Rate each of the following symptoms based upon your typical health profile for: ☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale		
0	*Never* or almost never have the symptom	
1	*Occasionally* have it, effect is not severe	
2	*Ocasionally* have it, effect is severe	
3	*Frequently* have it, effect is not severe	
4	*Frequently* have it, effect is severe	

Medical Symptoms Questionnairre

HEAD
- ______ Headaches
- ______ Faintness
- ______ Dizziness
- ______ Insomnia
- ______ TOTAL

EYES
- ______ Watery or itchy eyes
- ______ Swollen, reddened or sticky eyelids
- ______ Bags or dark circles under eyes
- ______ Blurred or tunnel vision (does not include near- or far-sightedness)
- ______ TOTAL

EARS
- ______ Itchy ears
- ______ Earaches, ear infections
- ______ Drainage from ear
- ______ Ringing in ears, hearing loss
- ______ TOTAL

NOSE
- ______ Stuffy nose
- ______ Sinus problems
- ______ Hay fever
- ______ Sneezing attacks
- ______ Excessive mucus formation
- ______ TOTAL

MOUTH/ THROAT
- ______ Chronic coughing
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, hoarseness, loss of voice
- ______ Swollen or discolored tongue, gums or lips
- ______ Canker sores
- ______ TOTAL

SKIN
- ______ Acne
- ______ Hives, rashes, dry skin
- ______ Hair loss
- ______ Flushing, hot flashes
- ______ Excessive sweating
- ______ TOTAL

HEART
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat
- ______ Chest pain
- ______ TOTAL

LUNGS
- ______ Chest congestion
- ______ Asthma, bronchitis
- ______ Shortness of breath
- ______ Difficulty breathing
- ______ TOTAL

DIGESTIVE TRACT
- ______ Nausea, vomiting
- ______ Diarrhea
- ______ Constipation
- ______ Bloated feeling
- ______ Belching, passing gas
- ______ Heartburn
- ______ Intestinal/stomach pain
- ______ TOTAL

JOINTS / MUSCLE
- ______ Pain or aches in joints
- ______ Arthritis
- ______ Stiffness or limitation of movement
- ______ Pain or aches in muscles
- ______ Feeling of weakness or tiredness
- ______ TOTAL

WEIGHT
- ______ Binge eating/drinking
- ______ Craving certain foods
- ______ Excessive weight
- ______ Compulsive eating
- ______ Water retention
- ______ Underweight
- ______ TOTAL

ENERGY / ACTIVITY
- ______ Fatigue, sluggishness
- ______ Apathy, lethargy
- ______ Hyperactivity
- ______ Restlessness
- ______ TOTAL

MIND
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Poor concentration
- ______ Poor physical coordination
- ______ Difficulty in making decisions
- ______ Stuttering or stammering
- ______ Slurred speech
- ______ Learning disabilities
- ______ TOTAL

EMOTIONS
- ______ Mood swings
- ______ Anxiety, fear, nervousness
- ______ Anger, irritability, aggressiveness
- ______ Depression
- ______ TOTAL

OTHER
- ______ Frequent illness
- ______ Frequent or urgent urination
- ______ Genital itch or discharge
- ______ TOTAL

GRAND TOTAL ______

Courtesy of FirstLine Therapy

Xenobiotic Tolerability Test

1. Are you presently using prescription drugs?
☐ Yes (1 pt)

If yes, how many are youcurrently taking? ___ (1 pt ea
☐ No (0 pt)

2. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2 pts)
☐ Acetaminophen (2 pts)
☐ Estradiol (2 pts)

3. If you have used or currently use prescription drugs which of the following scenarios best represents your response to them:
☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts)
☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts)
☐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts)
☐ Experience no side effects, drug(s) is (are) usually efficacious (0 pt)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
☐ Yes (2 pts) ☐ No (0 pt)

5. Do you have strong negative reaction to caffeine or caffeine containing products?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't Know (0 pt)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt) ☐ No (0 pt)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't Know (0 pt)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't Know (0 pt)

9. Do you have a personal history of
☐ Environmental and/or chemical sensitivities (5 pts)
☐ Chronic fatigue syndrome (5 pts)
☐ Multiple chemical sensitivity (5 pts)
☐ Fibromyalgia (3 pts)
☐ Parkinson's type symptoms (3 pts)
☐ Alcohol or chemical dependence (2 pts)
☐ Asthma (1 pt)

10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt) ☐ No (0 pt)

11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc.?
☐ Yes (1 pt) ☐ No (0 pt) ☐ Don't Know (0 pt)

OVERALL SCORE TABULATION

MSQ Score __________ (High > 50; moderate 15-49; Low < 14)

XTT Score __________ (High > 10; moderate 5-9; Low < 4)

			Functional Medicine Protocol		
MSQ Score	XTT Score	Description	Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimina-tion diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimina-tion diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support	
Symptom	Nutraceutical Support
Water retention and/or frequent or urgent urination	Kidney support netraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not relatied to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body.

Courtesy of FirstLine Therapy

Informed Consent for Physical Therapy & Chiropractic Treatment and Care

I hereby request and consent to the performance of physical therapy procedures and 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 medical doctor and/or the doctor of chiropractic named below and/ or other board certified doctors or 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 doctors 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 adjustments and physical therapy, 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(s) named below and/or office personnel the nature, purpose and risks of physical therapy and 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 physical therapy treatments. 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 treatments 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 A MINOR OR PHYSICALLY OR LEGALY INCAPACITATED

Patient Name: ______________________ Name of Representative: ______________________

Date Signed: ______________ Signature of Representative: ______________________

Relationship or Authority of Patient's Representative: ______________________

Translated By: ______________________ Date: ______________

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office: **Ronald D. Zlotolow Medical Group Inc. DBA The Vitality Health Center**

Address: 2232 Santa Monica Blvd, STE 101, Santa Monica, CA 90404
Names of doctors treating this patient: Dr. Yariv Rothman, DC and Dr. Ronald Zlotolow, MD

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