5 Years – 18 Years old

Vita Nova
HEALTHY HAPPY INSPIRED

CLIENT INFORMATION:

Date: _____ Whom may we thank for referring you: _____ (Office use Client Number): _____

Client's Last Name: _____ First: _____ M.I.: _____

Date of Birth: _____ /_____ /_____ Age: _____ Name of Parents/Guardians: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone numbers: Home: ( ) _____ Cell: ( ) _____

Phone carrier? (Please circle) *Verizon, T-Mobile, AT&T, Sprint,* or *Other:* _____

E-mail Address: _____ How would you prefer to receive an appointment reminder? ☐ E-mail and/or ☐ Text

Other children's names and ages: _____

OTHER DOCTORS

Dr.'s Name: _____ Type of Dr.: _____ Last Appointment Mon/Yr:_____

Dr.'s Name: _____ Type of Dr.: _____ Last Appointment Mon/Yr:_____

Have you had X-rays taken: ☐ **Yes** ☐ **No**

INSURANCE

We do not take insurance as payment. We can provide you with an insurance form to submit to your insurance company for your reimbursement.

FEES

FEES: Do you understand and accept these charges?

$225 X-rays and Film Analysis (Standard for First Appointment)

$125 Insight Scan, Exam & Report of Findings (Standard for First Appointment)

$110 Pediatric First Visit and 1st Adjustment

$185 Pregnancy First Visit and Adjustment

$60 Office Visit / Adjustment

$75 Re-Evaluation

$100 Office Visit for Nutritional Guidance / Wellness Coaching (Separate from the Adjustment)

***Note that all missed appointments without a phone call will be charged the full amount for visit. ***

***All cancellations must give a 4-hour notice or will be charged $20. ***

CLIENT'S SIGNATURE:

X_____

Signing gives permission for care (Parental Signature required for child under age 18) **Date**

Office Client Number: _____

HOW CAN WE HELP YOU?

"Our vision is to create a community of people that is healthy, happy and inspired." - **Vita Nova Spinal Care, P.C.**

Is your condition due to an auto or work-related accident? ☐ **No** ☐ **Yes** (If Yes, ask for an Accident Form)

The symptom(s) that have prompted me to seek care today: _____

They are the result of: ☐ An accident or injury ☐ A flare up of an old condition ☐ A new condition

Explain history of condition / cause of onset: _____

_____

When did you first start noticing your current symptoms? _____

How often does it occur? Constant or comes and goes? (Please explain) _____

Are there things that make this condition better? _____

Are there things that aggravate this condition? _____

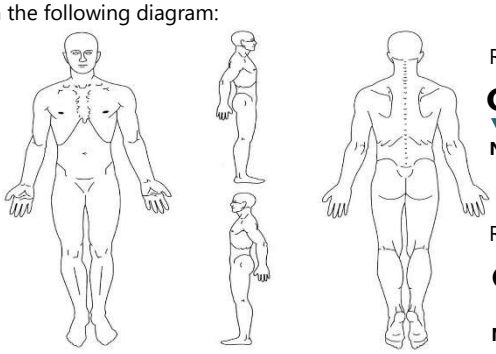
Does it travel to other areas of the body? Where? _____

What else should the doctor know about your current condition? _____

Please locate and describe the condition on the following diagram:

A	=	Aching	SH	=	Shooting
B	=	Burning	ST	=	Stiffness
C	=	Cramping	SW	=	Swelling
D	=	Dull	T	=	Tingling
N	=	Numbness	TH	=	Throbbing
S	=	Sharp	V	=	Stabbing

Other: _____



Rate the severity of the condition right now:

0 1 2 3 4 5 6 7 8 9 10

No Symptoms — **Intense Symptoms**

Rate the worst it has been in the past week:

0 1 2 3 4 5 6 7 8 9 10

No Symptoms — **Intense Symptoms**

IMPACT OF SYMPTOMS

How is the symptom / condition interfering with your life? (Check where appropriate)

	Mild Effect	Mod. Effect	Severe Effect		Mild Effect	Mod. Effect	Severe Effect
Work	☐	☐	☐	**Energy**	☐	☐	☐
Exercise	☐	☐	☐	**Attitude**	☐	☐	☐
Recreation	☐	☐	☐	**Patience**	☐	☐	☐
Relationship	☐	☐	☐	**Productivity**	☐	☐	☐
Sleep	☐	☐	☐	**Creativity**	☐	☐	☐
Self-Care	☐	☐	☐	**Other:** _____	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — **VERY COMMITTED**

NOTES: (DOCTOR'S USE ONLY)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

Office Client Number: _____

REVIEW OF SYSTEMS

"Chiropractic care focuses on the integrity of your nervous system, which controls and regulates every function in your body."

Mark applicable functional diseases by checking the box. **C**=Constant **F**=Frequent

Neurological	Muscle & Joint	Digestive	Cardiovascular	Eyes, Ears, Nose & Throat
C F	C F	C F	C F	C F
☐ ☐ Allergies	☐ ☐ Arthritis	☐ ☐ Colon problems / IBS	☐ ☐ High / Low BP	☐ ☐ Ear infection
☐ ☐ Anxiety/ Depression	☐ ☐ Hip disorders	☐ ☐ Hemorrhoids	☐ ☐ High cholesterol	☐ ☐ Eye infection
☐ ☐ Dizziness	☐ ☐ Knee pain	☐ ☐ Gall bladder trouble	☐ ☐ Poor circulation	☐ ☐ Sinus infection
☐ ☐ Nervousness	☐ ☐ Scoliosis	☐ ☐ Parasite/fungus	☐ ☐ Excessive bruising	☐ ☐ Ringing in ears
☐ ☐ Loss of sleep	☐ ☐ TMJ disorder	☐ ☐ Anorexia/bulimia	☐ ☐ Varicose veins	☐ ☐ Hearing loss
☐ ☐ Other: _____	☐ ☐ Other: _____	☐ ☐ Other: _____	☐ ☐ Other: _____	☐ ☐ Other: _____

Constitutional	Respiratory	Skin	Genitourinary	Female
C F	C F	C F	C F	C F
☐ ☐ Fainting	☐ ☐ Asthma	☐ ☐ Acne	☐ ☐ Bedwetting	☐ ☐ Heavy flow
☐ ☐ Fatigue	☐ ☐ Apnea	☐ ☐ Dryness	☐ ☐ Infertility	☐ ☐ Irregular cycle
☐ ☐ Low libido	☐ ☐ Difficulty breathing	☐ ☐ Eczema	☐ ☐ Kidney infection	☐ ☐ Painful cycle
☐ ☐ Poor appetite	☐ ☐ Emphysema	☐ ☐ Rash	☐ ☐ Erectile dysfunction	☐ ☐ Discharge
☐ ☐ Weakness	☐ ☐ Chronic cough	☐ ☐ Yeast/fungal	☐ ☐ Prostate issues	Menopausal ☐ YES ☐ NO
☐ ☐ Other: _____	☐ ☐ Other: _____	☐ ☐ Other: _____	☐ ☐ Other: _____	☐ ☐ Other: _____

Previously Diagnosed Conditions: _____

REVIEW OF STRESSORS

"Disease is caused when the body is unable to maintain homeostasis (balance). There are three forms of stress that cause imbalance in the body."

Thoughts & Emotions

Please list any negative thought patterns that effect your daily life:

_____

_____

_____

_____

_____

_____

Traumas

Please list any past traumas, accidents, injuries, falls and/or operations:

_____

_____

_____

_____

_____

_____

Toxins

Please check yes/no to those that apply:

Eat processed food: ☐ **YES** ☐ **NO**
On any medication: ☐ **YES** ☐ **NO**
Take daily vitamins: ☐ **YES** ☐ **NO**
Use marijuana: ☐ **YES** ☐ **NO**
Mercury fillings: ☐ **YES** ☐ **NO**
Do you smoke: ☐ **YES** ☐ **NO**
Vaccines: ☐ **YES** ☐ **NO**

Dr.'s Notes: _____

_____

NUTRITION

How is your nutrition? (Please circle)

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Poor
(processed & fast food)

Fair
(nutrition inconsistent)

Excellent
(fruits, vegetables, proteins & healthy fats)

Estimated amount per day:

☐ Caffeine ____ oz ☐ Soda _____ oz ☐ Water _____ oz

Are you interested in a nutritional consultation? ☐ **Yes** ☐ **No**

Office Client Number: _____

PATIENT WELLNESS ASSESSMENT

"Our purpose is to help people live more in accord with whom God designed them to be."
- Vita Nova Spinal Care, P.C.

On the arrow diagram above:

What number do you think represents your health today? _____

In what direction is your health currently headed? Towards: ☐ **RED** or ☐ **PURPLE**

What are your health goals?

IMMEDIATE: _____

SHORT TERM (6 Month – 1 Year): _____

LONGER TERM (3 Year +): _____

ACKNOWLEDGMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ I understand that the chiropractic care offered in this office is based on the best available evidence and is designed to reduce or correct the vertebral subluxation complex. I realize chiropractic is separate from medicine and does not claim to cure any disease. With this knowledge, I permit the chiropractor to deliver care that, in his professional judgment, can best help me in the restoration of my health.

_____ I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I acknowledge that I have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ I authorize the performance of x-ray examination of (CIRCLE: myself, my child) which Dr. Mario Chavez, D.C., may consider necessary or advisable in the course of treatment. I acknowledge that these x-rays are the sole property of Vita Nova Spinal Care, P.C., and as such will be used exclusively for purposes unique to the care of Dr. Mario Chavez, D.C.

_____ For women: I certify I am not pregnant and realize an x-ray examination may be hazardous to an unborn child. Date of last menstruation period. (MM/DD/YYYY) _____

_____ I grant permission for this office to confirm or reschedule an appointment by phone, and to be sent occasional health related cards, letters, or emails.

_____To my best knowledge, the information supplied is complete and truthful without misrepresentation of the existence, origin or severity of my health concerns.

_____ I acknowledge I am responsible for payments of any insurance covered or non-covered services I receive, and any insurance coverage is an agreement between the carrier and me. I understand that Vita Nova Spinal Care, P.C. is not a provider for insurance and is considered an out of network provider.

If the client is a minor, print their full name and age: _____

CLIENT'S SIGNATURE: (Parental Signature required for child under age 18)

X

Signing gives permission for care **Date**