PURE HEALTH
AND VITALITY

Confidential Intake Form

CONTACT INFORMATION

Last Name	First Name

Address	City	State	Zip

Email Address

Home Phone	Work Phone	Cell Phone
( )	( )	( )

Employer	Position

OTHER INFORMATION

Birthday	Age	Gender	SSN	Driver's License
/ /		M/F		

Referred by

GENERAL HEALTH INFORMATION

Height	Weight	Adult Max	Adult Min
	lbs	lbs	lbs

PURPOSE(S) AND/OR HEALTH CONCERN(S)

Instructions: List the purpose(s) of this appointment and/ot each major health concern you have.

1. _____
2. _____
3. _____
4. _____
5. _____

Current Health History

HEALTH CONCERN INFORMATION

Instructions: Fill out separate 'current health history' sheets for each health concern you listed above Mark the location of the concern or area of pain on the diagram provided.

Purpose/Concern: _____

_____

_____

_____

_____

When did this begin? _____

How (if known) did this begin? _____

_____

_____

Have you had this before? ☐ **No** ☐ **Yes, when:** _____

What makes this worse? _____

_____

What makes this better? _____

_____

Circle the current intensity of this on a scale of 0 (no problem) to 10 (worst): 1 2 3 4 5 6 7 8 9 10

Is this getting worse: ☐ **No** ☐ **Yes** ☐ **Comes and goes** ☐ **It is consistent**

Is this worse at a certain time of day/month? _____

What does this prevent you from doing? _____

_____

Have you seen other doctors for this? ☐ **No** ☐ **Yes, Dr.'s name(s):** _____

_____

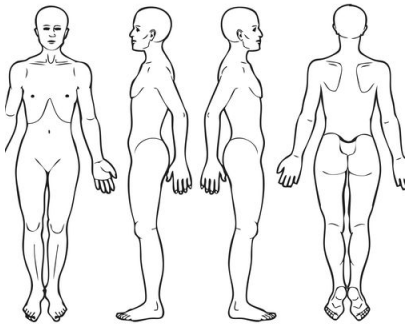
Treatment: _____ **Results:** _____

Is this an accident related condition? ☐ **No** ☐ **Work injury** ☐ **Automobile injury** ☐ **Other**

_____

Notes:

Location of health concern



Past Health Page 1

PAST SURGERIES

Check any of the following surgeries you have had. Include approximate dates:

- ❑ **Appendectomy: _____**
- ❑ **Gallbladder: _____**
- ❑ **Hernia: _____**
- ❑ **Back: _____**
- ❑ **Neck: _____**
- ❑ **Broken Bones: _____**
- ❑ **Mastectomy: _____**
- ❑ **Tonsillectomy: _____**

List any others. Include approximate dates:

1. **_____ Date: _____**
2. **_____ Date: _____**

PAST DISEASE AND INFECTIONS

Check any of the following diseases you've have had:

- ❑ **Pneumonia**
- ❑ **Anemia**
- ❑ **Measles**
- ❑ **Polio**
- ❑ **Rheumatic Fever**
- ❑ **Tuberculosis**
- ❑ **Whooping Cough**
- ❑ **HIV+**
- ❑ **Mumps**
- ❑ **Heart Disease**
- ❑ **Thyroid Disorder**
- ❑ **Chicken Pox**
- ❑ **Small Pox**
- ❑ **Diabetes**
- ❑ **Cancer**
- ❑ **Hepatitis C**
- ❑ **Influenza**
- ❑ **High Blood Pressure**
- ❑ **Eczema**
- ❑ **Arthritis**
- ❑ **Pleurisy**
- ❑ **Epilepsy**
- ❑ **Mental Disorders**
- ❑ **High Cholesterol**

PAST TRAUMAS AND ACCIDENTS

List all previous traumas or accidents that might be related to your current health concern(s):

1. **_____ Date: _____**
2. **_____ Date: _____**
3. **_____ Date: _____**
4. **_____ Date: _____**

HOSPITALIZATIONS

List all previous traumas or accidents that might be related to your current health concern(s):

1. **_____ Date: _____**
2. **_____ Date: _____**
3. **_____ Date: _____**
4. **_____ Date: _____**

ALLERGIES

List any known allergies you have: _____

_____

NOTES:

Past Health History Page 2

Check any of the following that apply and describe the amount:

Intake	Quantity	Intake	Quantity
❑ Coffee	_____	❑ Sugar/Starches	_____
❑ Tea	_____	❑ Soft Drinks	_____
❑ Alcohol	_____	❑ Fast Food	_____
❑ Cigarettes	_____	❑ Meals/Day	_____
❑ Cigars	_____	❑ Exercise	_____
❑ Other Tobacco	_____	❑ Sleep	_____
❑ Recreational Drugs	_____	❑ Other	_____

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS

Medication	Dose/Frequency	Purpose	Medication	Dose/Frequency	Purpose
1.	/		11.	/	
2.	/		12.	/	
3.	/		13.	/	
4.	/		14.	/	
5.	/		15.	/	
6.	/		16.	/	
7.	/		17.	/	
8.	/		18.	/	
9.	/		19.	/	
10.	/		20.	/	

FAMILY HISTORY

Instructions: Please indicate if any of the following family members have any disease(s), if they have passed on please indicate the cause of death and approximate age when they died.

Father's Mother:
Father's Father:
Father's Grandparents:
Father's Siblings:
Father:
Mother:
Mother's Mother:
Mother's Father:
Mother's Grandparents:
Mother's Siblings:
Your Siblings:
Your Children:

Past Health HIstory Page 3

REVIEW OF SYSTEMS

In the last year, have you experienced any of the following problems? Check all that apply.

- ❑ Eating disorders
- ❑ Compulsivity (including compulsive eating)
- ❑ Increased hunger & weight gain after dieting
- ❑ Myoclonus (twitching muscles or legs)
- ❑ Depression
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Irritable bowel syndrome
- ❑ Migraine headaches
- ❑ PMS
- ❑ Insomnia (sleep 4+ hours per night with wake ups)
- ❑ Anorexia
- ❑ Bulimia
- ❑ Impulsivity
- ❑ Obsessionality
- ❑ Fibromyalgia
- ❑ Neurodermatitis
- ❑ Sleep apnea
- ❑ TMJ syndrome
- ❑ Bipolar disorder
- ❑ Mania
- ❑ Aggression
- ❑ Self-injury
- ❑ Chronic pain state

FEMALE SECTION ONLY

Age of onset _____ Are your periods regular? ☐ Yes ☐ No, Explain: _____

_____

Your cycle is: _____ days (from start to finish) Date of last period: _____

Menstrual flow: ☐ Light ☐ Medium ☐ Heavy ☐ Other: _____

Do you take birth control pills or HRT? ☐ No ☐ Yes, what type:

_____

Check all of the following premenstrual symptoms that apply:

- ❑ Anxiety
- ❑ Irritability
- ❑ Anger
- ❑ Agitation
- ❑ Cramps
- ❑ Fat Gain
- ❑ Gallbladder
- ❑ Polycystic Ovaries
- ❑ Heavy Bleeding
- ❑ Prolonged Bleeding
- ❑ Clots
- ❑ Water Retention
- ❑ Weight Gain
- ❑ Cold Hands/Feet
- ❑ Infertility
- ❑ Fibroids
- ❑ Bloating
- ❑ Breast Tenderness
- ❑ Breast Enlargement
- ❑ Fibrocystic Breasts
- ❑ Mood Swings
- ❑ Blood Sugar Problems
- ❑ Insomnia
- ❑ Cervical Dysplasia
- ❑ Depression
- ❑ Headaches/Migraines
- ❑ Food Cravings
- ❑ Chocolate Cravings
- ❑ Irregular Periods
- ❑ Osteoporosis
- ❑ Autoimmune Disorder
- ❑ Muscle Pains
- ❑ Joint Pains
- ❑ Back Pain
- ❑ Acne
- ❑ Foggy Thinking
- ❑ Decreased Sex Drive
- ❑ Endometriosis
- ❑ Cancer

MALE SECTION ONLY

Do you have a history of prostate problems: No Yes, explain: _____

List any additional make related changes/issues/concerns: _____

_____

Notes:

Pure Health and VItality Policies

NOTICE OF FINANCIAL RESPONSIBILITY

Pure Health and Vitality LLC is very pleased to have you as a new patient. We are honored you have selected our clinic for your care.

In many cases, your insurance will cover part or all of chiropractic care or lab work of nutrition services. We will work with you to insure that you have all necessary documentation to file with your insurance carrier, motor vehicle insurer, or work related insurer, so they can process and pay your claims. However, we are out of network and you are ultimately responsible for any service at PHV. Your payment is required either at the time of service or if other payment arrangements (insurance or not) have been approved and signed by management.

You are responsible for paying all costs for treatment not reimbursed by the insurance company, despite our efforts in collecting. If your motor claim is in dispute and there is no other insurance coverage for your treatments, PHV will reserve the right to collect prior to settlement. However, you are ultimately responsible for payment in full for services you receive.

If it is necessary to initiate action to collect any unpaid balance on your account, you agree to pay reasonable costs of collection, including necessary attorney fees and court costs.

Upon request, billing statements will be given on the 30th of every month. Payment is required on the day of service. Pure Health and Vitality is an out of network practice. We will bill insurance when an out of network deductible will be met. In these cases, patients must bring any insurance checks they receive to Pure Health and Vitality. Any insurance billing is not a requirement and is at PHV discretion.

Patients are required to provide 24 hour notice prior to any PHV services and 72 hour notice for any examinations or visits lasting longer than 15 minutes. Failure to provide medical (Dr. note), proof of emergency will be charged for the amount of the appointment scheduled.

For your protection, all retail purchases are final.

I authorize Pure Health and Vitality or its billing agency to release any information acquired in the course of my care to my insurance company or persons representing my case.

My signature below is proof that I have read and understand the above policies for Pure Health and Vitality Inc.

Signature _____ Date _____