## Pura Vida Patient Information

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Who can we thank for referring you to our office:___________________________________ Date: _____________

First Name: ___________________________________ Last Name: _______________________________________

Date of Birth: ______ / ______/ ______ ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Name of Spouse/significant other: ___________________________________ Number of children: _________
Address: ________________________________________City: _____________________State: ____ Zip: _______
Phone: Cell: _______________________Work:__________________________ SSN: ________________________
E-Mail Address: _____________________________________________________________________________
Preferred Method of Contact: Call ____ Text ____ Email ___

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What are your **main reasons** for consulting with our office today? (List concerns in order of importance to you)

1) _____________________________________________________ When did issue begin? ____________________
2) _____________________________________________________ When did issue begin? ____________________
3) _____________________________________________________ When did issue begin? ____________________
4) _____________________________________________________ When did issue begin? ____________________

What do you believe caused your current health problems?

_______________________________________________________________________________________________

Are you in pain today? ___Yes ___No (Circle) 0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

| How often are your symptoms present? | _Constantly | _Frequently | _Occasional |
|---|---|---|---|
| **Describe your current pain/symptoms:** | _Sharp/Stabbing<br>_Dull<br>_Numbness<br>_Burning | _Throbbing<br>_Soreness<br>_Shooting<br>_Tingling | _Aches<br>_Weakness<br>_Gripping<br>_Other___________________ |
| **Since it began, is your problem:** | _Improving | _Getting Worse | _No change |
| **What makes the problem better?** | _Nothing<br>_Standing<br>_Exercising | _Lying Down<br>_Sitting<br>_Inactivity/Rest | _Walking<br>_Movement<br>_Other___________________ |
| **What makes the problem worse?** | _Nothing<br>_Standing<br>_Exercise | _Lying Down<br>_Sitting<br>_Inactivity/Rest | _Walking<br>_Movement<br>_Other___________________ |

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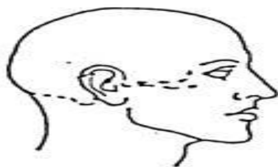
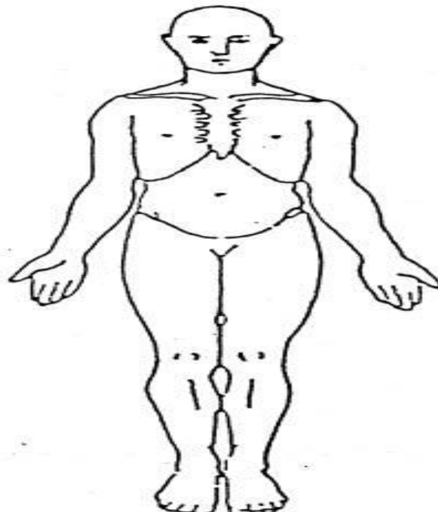
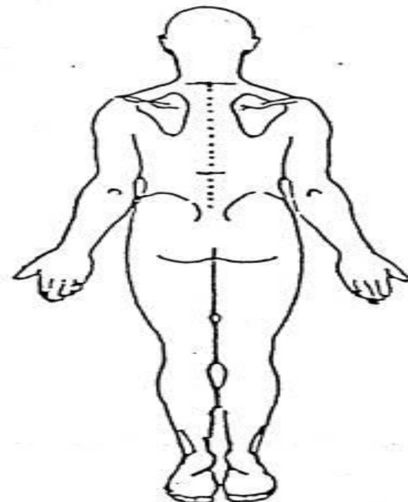
Mark (X) on the picture where you have pain or other symptoms;

Please check any daily activities which suffer as a result of your health complaints:

| ☐ Sports | ☐ Family Time | ☐ Cleaning | ☐ Exercise | ☐ Work |
|---|---|---|---|---|
| ☐ Sleep | ☐ Hobbies | ☐ Cooking | ☐ Bathing | ☐ Other |

Have you ever had any imaging for this complaint? (MRI, CT, US, X-rays): ____________________Date:________

Have you ever had any blood work for this condition? __Yes ___No _________________________Date:________

What treatments have you undergone in the past that has not fixed your complaint?

| ☐ Medications | ☐Physical Therapy | ☐ Injections | ☐ Massage | ☐ Chiropractic |
|---|---|---|---|---|
| ☐ Acupuncture | ☐Personal Training | ☐ Homeopathy | ☐ Herbs | ☐ Exercise |

Other: ____________________________________________________________________________

**Prior Chiropractic Experience:**

Have you been to a Chiropractor in the past? ☐ Yes ☐ No

If yes: Date of your last Adjustment: ___________

Why are you changing Chiropractors: ______________________________________________________

What did you LIKE most about your past experience: __________________________________________

Are you familiar with the term "**Subluxation**"? ☐ Yes ☐ No

There are options for care in our office, check the types of care you would like to review with the Doctor:

☐ **Relief-** Addresses acute symptoms only and is **only** a temporary solution.
☐ **Corrective**- Addresses the underlying causes of your problem & allows your body to function at your best.
☐ **Wellness** - Apply specific strategies to KEEP you and your family healthy and happy.

*If care is offered to you, are there any reasons you could not follow our recommendations? Yes No

Please explain: ______________________________________________________________________

Where do you believe your overall Quality of Life is *today* on a scale of 1-10 (*10 is optimal*): ___________

Where do you *want your life and health* to be in the *future* (1-10): _________

How *committed* are you to do what it takes to regain your health? (1-10): __________

What are your expectations for your visit today?_________________________________________________

______________________________________________________________________________________

May we send your test results and our recommendations to your Medical Doctor? ☐ Yes ☐ No

Your Medical Doctor's Name and Phone#:______________________________________________________

**Your Quality of Life**

Please rate each below on a scale from 0-10. 0 - Inadequate - 5 - Moderate - 10 - Optimal

| | | | |
|---|---|---|---|
| Energy | ←0---1---2---3---4---5---6---7---8---9---10→ | Focus | ←0---1---2---3---4---5---6---7---8---9---10→ |
| Sleep | ←0---1---2---3---4---5---6---7---8---9---10→ | Family | ←0---1---2---3---4---5---6---7---8---9---10→ |
| Mood | ←0---1---2---3---4---5---6---7---8---9---10→ | Career | ←0---1---2---3---4---5---6---7---8---9---10→ |
| Digestion | ←0---1---2---3---4---5---6---7---8---9---10→ | Friends | ←0---1---2---3---4---5---6---7---8---9---10→ |

PLEASE list all over the counter and prescription, herbs, supplements you are taking on a monthly basis:

❑Aspirin ❑Pain Killers ❑Tranquilizers ❑Insulin ❑Birth Control Pills ❑ Blood Thinners

| Medication/ Supplement | Dose | Frequency of Use | Reason for Taking | Start Date | Prescribed By: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Stress is a reality in our daily lives! The goal is to help your body function optimally, thereby allowing you to adapt and stay healthy, despite exposure to stress. The Doctor needs to know as much as possible about your CURRENT and PAST history of exposures to stress to BEST understand your test results, and give you the best recommendations for care! Please be thorough as you check all of the boxes below that you've experienced.

Your Occupation: ______________________________________________ # of years in that field: ______

Daily Total: Work Hours: ______ Computer Work: ______ Reading: ______ Sitting:_____ Standing: ______

Sleep Schedule: Sleep at what time; _________________ You typically rise at what time: ___________

Special Diet: _________________________________________________________________________________

**Surgery:**

- ☐ Surgery/Stitches Area:____________________
- ☐ Cosmetic Surgery Area:____________________

**Physical Stress:**

- ☐ Birth Trauma
- ☐ Forceps/Suction/C-Section
- ☐ Sports Played/Year:_________
- ☐ Head/ Neck Injuries/Year:_________
- ☐ Broken Bones:_____________
- ☐ Poor Arches/Flat Feet
- ☐ Excessive Exercise
- ☐ Car Accidents/How Many?___ Dates:_______ Injury:________
- ☐ Dislocated Joints
- ☐ Sleep on Stomach
- ☐ No Exercise
- ☐ Texting/ Lap top

**Chemical Stress:**

- ☐ Antibiotics Condition/Date Last Dose:_____________
- ☐ Labor Induced
- ☐ Tobacco
- ☐ Diet Sodas/artificial sweeteners
- ☐ Processed Foods
- ☐ Hormones (HRT) Started: _________________
- ☐ Chemical/Factory Work
- ☐ Alcohol Use
- ☐ Soda/Pop/Cola
- ☐ Diet Pills
- ☐ Caffeine Amount Consumed: __________
- ☐ Sugar, Cakes, Candy
- ☐ Fast Food ___________
- ☐ Low Water Intake
- ☐ Stimulant Pills

**Emotional Stress:**

- ☐ You/Loved One Hospitalized Dates:__________________
- ☐ Birth of Child
- ☐ Divorce/Separated
- ☐ Career Change
- ☐ Recent Move
- ☐ Anger
- ☐ Chronic Sickness: Dates: __________________
- ☐ Marriage
- ☐ Death of a Loved One
- ☐ Feeling Overwhelmed
- ☐ ADD/ADHD
- ☐ Relationship Stress
- ☐ Family Sickness: Dates:________________
- ☐ Low Self-Esteem
- ☐ Financial Stress
- ☐ Depression/Boredom
- ☐ Memory Issues
- ☐ Procrastination/Indecisive

**Women:**

☐ Fertility issues ☐ PMS ☐ Are you pregnant? ☐ Yes ☐ No Due Date:_________ ☐ Heavy Periods/ Severe ☐ Cramps/ Fibroids ☐ Breast Implants ☐ Birth Control Pills Nursing ? ☐ Yes ☐ Last Menstrual Cycle: ___________
☐ Menstrual Problems ☐ Breast Soreness ☐ Endometriosis ☐ Menopausal

**Health Problems in your immediate family**: Please indicate what member and year of diagnosis

☐ High Blood Pressure/Strokes: ____________________________________________________
☐ Asthma/Allergies: ______________________________________________________________
☐ Cancers: ______________________________________________________________________
☐ Heart Disease: _________________________________________________________________
☐ Other significant family history: _______________________________________________

# Review of Systems

**Cardiovascular:**

| | Present: | Past: | No: |
|---|---|---|---|
| Aortic Aneurism | ☐ | ☐ | ☐ |
| Cardiac Catheter | ☐ | ☐ | ☐ |
| Angina (Chest Pain) | ☐ | ☐ | ☐ |
| Poor Circulation | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ |
| Irregular Heartbeat | ☐ | ☐ | ☐ |
| Pace Maker | ☐ | ☐ | ☐ |
| Swelling of Legs | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |

**Genitourinary:**

| | Present: | Past: | No: |
|---|---|---|---|
| Blood in Urine | ☐ | ☐ | ☐ |
| Burning in Urination | ☐ | ☐ | ☐ |
| Frequent Urination | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ |
| Kidney Stone | ☐ | ☐ | ☐ |
| Urinary Tract Infection | ☐ | ☐ | ☐ |

**Hematologic Lymphatic:**

| | Present: | Past: | No: |
|---|---|---|---|
| Blood Clots | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ |
| Easy Bruising/Bleeding | ☐ | ☐ | ☐ |
| Fevers/Chills/Sweats | ☐ | ☐ | ☐ |

**Respiratory:**

| | Present: | Past: | No: |
|---|---|---|---|
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Cold/Flu | ☐ | ☐ | ☐ |
| Cough/Wheezing | ☐ | ☐ | ☐ |
| Emphysema/COPD | ☐ | ☐ | ☐ |
| Pneumonia | ☐ | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |

**Ears/Eyes/Nose/Throat:**

| | Present: | Past: | No: |
|---|---|---|---|
| Bleeding Gums | ☐ | ☐ | ☐ |
| Difficulty Swallowing | ☐ | ☐ | ☐ |
| Dizziness/Vertigo | ☐ | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ | ☐ |
| Nosebleed | ☐ | ☐ | ☐ |
| Ringing in Ears (Tinnitus) | ☐ | ☐ | ☐ |
| Sinus Infection (Sinusitis) | ☐ | ☐ | ☐ |
| Sore Throat | ☐ | ☐ | ☐ |
| Swollen Glands/Lymph | ☐ | ☐ | ☐ |
| Blurred/Double Vision | ☐ | ☐ | ☐ |
| Cataracts/Glaucoma | ☐ | ☐ | ☐ |
| Loss of Vision | ☐ | ☐ | ☐ |

**Psychiatric:**

| | Present: | Past: | No: |
|---|---|---|---|
| Anxiety Disorder | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Eating Disorder | ☐ | ☐ | ☐ |
| PTSD | ☐ | ☐ | ☐ |
| Bipolar | ☐ | ☐ | ☐ |

**Integumentary:**

| | Present: | Past: | No: |
|---|---|---|---|
| Eczema | ☐ | ☐ | ☐ |
| Skin Cancer | ☐ | ☐ | ☐ |
| Psoriasis | ☐ | ☐ | ☐ |
| Rashes | ☐ | ☐ | ☐ |
| Dermatitis | ☐ | ☐ | ☐ |

**Allergic Immunologic:**

| | Present: | Past: | No: |
|---|---|---|---|
| Allergy Shots | ☐ | ☐ | ☐ |
| Cortisone Use | ☐ | ☐ | ☐ |
| Hives | ☐ | ☐ | ☐ |
| HIV/Aids | ☐ | ☐ | ☐ |

**Endocrine:**

| | Present: | Past: | No: |
|---|---|---|---|
| Diabetes | ☐ | ☐ | ☐ |
| Hair Loss | ☐ | ☐ | ☐ |
| Adrenal Disorder | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ |

**Neurological:**

| | Present: | Past: | No: |
|---|---|---|---|
| Tingling | ☐ | ☐ | ☐ |
| Numbness | ☐ | ☐ | ☐ |
| Carpal Tunnel | ☐ | ☐ | ☐ |
| Head Injury | ☐ | ☐ | ☐ |
| Meningitis | ☐ | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ | ☐ |
| Brain Aneurysm | ☐ | ☐ | ☐ |
| Parkinson’s Disease | ☐ | ☐ | ☐ |
| Seizures/ Epilepsy | ☐ | ☐ | ☐ |
| Severe Headaches | ☐ | ☐ | ☐ |
| Loss of Balance | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |

**Gastrointestinal:**

| | Present: | Past: | No: |
|---|---|---|---|
| Bloody Stools | ☐ | ☐ | ☐ |
| Bowel Problems | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ |
| Gallbladder Problems | ☐ | ☐ | ☐ |
| Liver (hepatitis/cirrhosis) | ☐ | ☐ | ☐ |
| Nausea/Vomiting | ☐ | ☐ | ☐ |
| Poor Appetite | ☐ | ☐ | ☐ |
| Stomach Ulcers | ☐ | ☐ | ☐ |
| Abdominal Pain | ☐ | ☐ | ☐ |
| Colitis | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ |

**Musculoskeletal**

| | Present: | Past: | No: |
|---|---|---|---|
| Arthritis | ☐ | ☐ | ☐ |
| Gout | ☐ | ☐ | ☐ |
| Joints Stiffness | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Tendinitis | ☐ | ☐ | ☐ |
| Low Back Pain | ☐ | ☐ | ☐ |
| Mid Back Pain | ☐ | ☐ | ☐ |
| Neck Pain | ☐ | ☐ | ☐ |
| Scoliosis | ☐ | ☐ | ☐ |
| Muscular Incoordination | ☐ | ☐ | ☐ |
| TMJ Dysfunction | ☐ | ☐ | ☐ |

Please be as thorough as possible. Knowledge of these conditions may influence the type of treatment/therapy you receive.

**Pura Vida Chiropractic**
**2318 NW Military Hwy Suite 103 San Antonio, TX 78231**
**P 210.685.1994**

## Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information(PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

**Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, ___________________________________(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

☐ I, ___________________________________(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care to those individuals designated by the doctor.

Patient or Parent Signature: _________________________________Date: ________________

## Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance does not pay on a timely manner, you may be asked to contact your insurance carrier.

**If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

**Assignment of Rights and Conveyance of Lien Interest**

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information and needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

**I instruct checks to be made payable to Pura Vida Chiropractic PLLC, and payment to be sent to 2318 NW Military Hwy Suite 103 San Antonio, TX 78231**

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award (s).

Patient or Parent Signature: ______________________________ Date: _________________

## INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

- I, the undersigned parent or legal guardian of ___________________________________ (minor child), hereby give my permission to the staff of Pura Vida Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time, I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: ______________________________Date: __________________