Vivify Health & Wellness
7677 Center Ave, Suite 203
Huntington Beach, CA 92647
Phone: 714-462-8844
Fax: 714-462-8448

www.VivifyWell.com
info@vivifywell.com

MEDICAL INTAKE FORM

PATIENT DEMOGRAPHIC INFORMATION:

Full Name: _____ Date: _____ Age: _____ Birth Date: _____

Address: _____
Street Residence City State Zip Code

Home Ph. (_____) _____-_____, Cell Ph. (_____) _____-_____,Work Ph. (_____) _____-_____.

Social Security # _____-_____-_____ Driver's Lic. # _____, Height_____Weight_____

E-Mail_____, **Can we contact you by email? ❑ Yes ❑ No**

Spouse_____, Phone (_____) _____

If Patient under age of 18, Parent Name: _____, Phone (_____) _____

Contact Name in case of emergency: _____, Phone (_____) _____

Primary Care Provider Name:_____ **Primary Care Pone #** (_____) _____

Who may we thank for referring you to our office?_____

What are your objectives in consulting our office? ❑ Chiropractic care, ❑ Physical Medicine, ❑ Regenerative Medicine (PRP &/or Stem Cell therapies), ❑ Weight Loss, ❑ Nutritional / Functional Medicine, ❑ Bioidentical Hormone Replacement Therapy, ❑ Testosterone Replacement Therapy, ❑ Allergy Testing, ❑ B12 shots, ❑ Other: _____

INSURANCE INFORMATION:

Is your visit as a result of an Auto Collision, Injury at Work, or a Personal Injury? ❑ Yes ❑ No

Type of Insurance: ❑PPO ❑HMO ❑Kaiser ❑Medicare ❑ MediCal ❑ Med-Pay/Auto ❑ Attorney Lien ❑ Worker's Comp

***Please give insurance card and driver's license to front desk staff to scan, we will do a complimentary benefit check.**

Who is responsible for the insurance account? ❑ Self, ❑ Spouse. ❑ Family member_____

Primary Insurance Company:	Phone #	Effective Date:
ID #:	Group #:	
Secondary Insurance Company:	Phone #	Effective Date:
ID #:	Group #:	

I understand and agree to the following: There is no guarantee that my health insurance plan or policy will pay for all or part of my care. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered at Vivify Health & Wellness.

Patient's (*or guardian's*) signature: _____ **Date**: _____

ASSIGNMENT OF BENEFIT

I authorize that payment of charges be made directly to the Vivify Health & Wellness Center. This authorization includes: (1) All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy. (2) Amounts owed on my behalf from proceeds of any settlement related to my case.

Patient's (*or guardian's*) signature_____ **Date**_____

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CONSENT TO EXAMINATION

By signing below, I do hereby give consent to having a medical history taken and physical examination performed by the health care providers of Vivify Health & Wellness Center.

Patient's signature_____ **Date**_____

HEALTH AND SOCIAL HISTORY:

Employment:		Job Title:_____ Employer:_____ ❑ Desk/Computer work ❑ Manual Labor ❑ other:_____
Alcohol:	❑ Yes ❑ No	**If yes:** ❑ Daily. ❑ Moderate, <1 drink/day, ❑ Occasional <1 drink/week, ❑ Rare <1 drink/month ❑ Social only, ❑ with stress/anxiety, ❑ Drink in the morning, ❑ Your drinking concerns you, ❑ You feel guilt about your drinking, ❑ Sometimes have a drink first thing in the morning.
Tobacco:	❑ Yes ❑ No	**Type**: ❑ Cigarette. ❑ Chew, ❑ Other:
Marijuana:	❑ Yes ❑ No	❑ smoke, ❑ Edible, ❑ Vaporization, ❑ Tincture, ❑ Topical ❑ Other:_____ ❑ CBD only (no THC), ❑ Recreational use, ❑ Medicinal use
Drug Use:	❑ Yes ❑ No	**Explain:**
Exercise:	❑ No routine exercise ❑ Occasional routine exercise ❑ Regular Exercise (3-5 times a week) ❑ Daily Exercise (6-7 times a week) What do you do for exercise?	
Sleep:	❑ >8 hrs/night, ❑ 8 hrs/night, ❑ 6-8 hrs/night, ❑ <6 hrs/night	❑ Uninterrupted Sleep, ❑ Fragmented / Interrupted Sleep
	❑ Difficulty falling asleep, ❑ Difficulty waking up, ❑ Inability to get to deep restorative sleep How would you rate your quality of sleep? (very poor) 0 1 2 3 4 5 6 7 8 9 10 (very good)	
Stress:	How would you rate your stress level? (very low) 0 1 2 3 4 5 6 7 8 9 10 (very high) How often do you feel stressed? ❑ Never, ❑ Once a Week, ❑ More than Once a Week, ❑ Almost every Day, ❑ Always	
Sex:	❑ Not sexually active	❑ Sexually active, ❑ 1 partner, ❑ Multiple partners, ❑ Protected Sex, ❑ Unprotected sex. Are you experiencing difficulty with sexual arousal or function? ❑ Yes, ❑ No
Gender:	❑ Male, ❑ Female, ❑ Other, ❑ Different from birth	
Family:	❑ Single, ❑ Married, ❑ Divorced, ❑ Widowed, ❑ Cohabitated.	Number of children:____
Nutrition:	Dietary Restrictions: ❑ None ❑ Gluten Free, ❑ Vegan, ❑ Vegetarian, ❑ other: Food Sensitivities:_____ Food Allergies:_____ Average # of Meals a day: ❑ >3, ❑ 3, ❑ 2, ❑ 1. Average # of fast food meals/wk: ❑ >7, ❑ 3-7, ❑ 1-2, ❑ <1, ❑ 0. Water Intake: How many glasses, ounces, or milliliters per day?_____ Sodas per day? _____, Diet drinks per day? _____, Snacks per day? _____ (type of snack:_____) Nutritional supplements? ❑ Yes, ❑ No. If yes, please list:_____ _____	

Please list your primary health concerns or complaints that bring you here today:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

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HEALTH HISTORY QUESTIONNAIRE

Please List all Medical Conditions / Diagnoses:

Year	Condition	Year	Condition

Females Only:	Are you currently **pregnant?** ❑ Yes ❑ No	Are you currently **breast feeding**? ❑ Yes ❑ No

Please list all Surgeries / Procedures:

Year	Surgery	Year	Surgery

Please List Any Current Medications (including inhalers and over the counter), Supplements, or Vitamins

Please include drug name, dose strength, and how often taken.		

Please list all known Allergies or Bad Reactions to Medications:

Medication Name:	Type of Reaction:
❑ No Known Drug or Medication Allergies.	

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MEDICAL HISTORY - REVIEW OF SYSTEMS FORM

Patient Name: _____ Date: _____

Review of Systems – Please check each item "Yes" or "No" as they relate to your health:

CONSTITUTIONAL	Y	N	ENDOCRINE	Y	N	HEMATOLOGY/LYMPH	Y	N
Weight Loss			Loss of Hair			Easy Bruising		
Weight Gain			Difficulty with hot temperatures			Gums Bleed Easily		
Fatigue / low energy			Difficulty with cold temperatures			Enlarged Glands		
Night Sweats			Excessive hunger			Slow healing wounds/cuts		
Change in appetite			Frequent urination			**MUSCULOSKELETAL**		
Fever			Craving salty foods			Joint Pain/Swelling		
EYES			Craving sweets			Stiffness		
Glasses/Contacts			Excessive thirst			Muscle Pain		
Eye Pain			Dry skin			Muscle weakness		
Double Vision			Excessive sweating			Back Pain		
Cataracts			Dry or coarse hair			Neck Pain		
Glaucoma			Night sweats			**SKIN**		
EAR/NOSE/THROAT			Change in skin color			Rash/Sores		
Difficulty Hearing			Decreased sex drive / libido			Lesions		
Ringing in Ears			**GASTROINTESTINAL**			Itching/Burning		
Vertigo or dizziness			Heartburn/Reflux			Skin Infections		
Sinus Trouble			Nausea/Vomiting			Change in a mole		
Itchy eyes or nose			Constipation			Jaundice / yellowing		
Nasal Stuffiness			Diarrhea			Change in finger nails		
Frequent Sore Throat			Liver or gallbladder disease			Dry or oily skin		
CARDIOVASCULAR			Change in bowel movement			Acne		
Murmur			Jaundice			Eczema		
Chest Pain			Abdominal Pain			Psoriasis		
Palpitations (hearing racing heart)			Excessive gas / bloating			**NEUROLOGICAL**		
Dizziness			Black or Bloody bowel movement			Weakness/Loss of Strength		
Fainting Spells			**GENITOURINARY**			Numbness / tingling		
Shortness of Breath			Frequent urination			Headaches		
Difficulty Lying Flat			Feeling of urgency to urinate			Tremors		
Swelling Ankles or Feet			Painful/burning urination			Dizziness		
Increased heart rate			Waking up to urinate at nighttime			Memory Loss		
RESPIRATORY			Blood in Urine			Fainting Spells		
Cough			Erectile Dysfunction			**FEMALES ONLY**		
Coughing Blood			Abnormal Genital Discharge			Date Last Mammogram		
Asthma			Bladder Leakage or Incontinence			Ever had abnormal mamog		
Wheezing			Kidney stones (past or present)			Date Last PAP		
Chills			**PSYCHIATRIC**			Ever had abnormal PAP		
Shortness of Breath			Anxiety/Depression			Age of onset of periods		
ALLERGIC/IMMUNOLOGIC			Mood Swings			Age of onset menopause		
Hives/Eczema			Feelings of hopelessness			Regular / irregular periods		
Hay Fever / Seasonal allergies			Difficulty Sleeping			Number of pregnancies		
Frequent colds or flues			Thoughts of Suicide			Date last menstrual period		

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Pain Assessment (please complete if pain is part of your complaint) (PEG scale)

What number best describes your pain on average in the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain**

What number best describes how, during the past week, pain has interfered with your enjoyment of life?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

What number best describes how, during the past week, pain has interfered with your general activity?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

NEUROLOGICAL / MRI / VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? ☐ Yes ☐ No
   Comments:_____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐ Yes ☐ No
   Comments:_____
3. Do your hands or arms fall asleep regularly? ☐ Yes ☐ No
   Comments:_____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐ Yes ☐ No
   Comments:_____
5. Do you suffer from a loss of handgrip strength? ☐ Yes ☐ No
   Comments:_____
6. Do you suffer from back pain with pain in your buttocks, legs, or feet? ☐ Yes ☐ No
   Comments:_____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? ☐ Yes ☐ No
   Comments:_____
8. Do our legs or feet fall asleep regularly? ☐ Yes ☐ No
   Comments:_____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? ☐ Yes ☐ No
   Comments:_____
10. Do you suffer from cold hands or feet? ☐ Yes ☐ No
    Comments:_____
11. Do you suffer from seasonal or year round allergies? ☐ Yes ☐ No
    Comments:_____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? ☐ Yes ☐ No
    Comments:_____
13. Have you tried any Physical Therapy or Chiropractic treatments before? ☐ Yes ☐ No
    If yes: When? How long? What kind?:_____
14. Have you had an MRI? ☐ Yes ☐ No
    If yes: When? Who ordered it? What was it ordered for?:_____
15. Have you used any splint or braces or other prescribed treatment by an MD? ☐ Yes ☐ No
    If yes: When? What kind? Who ordered it?_____

Patient Signature: _____ Date: _____

To be completed by office staff only:

Signature of reviewing physician/provider: _____ Date:

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Patient Consent for use of Protected Health Information (PHI) For Treatment, Payment, & Healthcare Operations (TPO)

Print Patient Name:_____ Date of Birth:_____

Please initial and sign the following:

____ I consent to the use and/or disclosure of my Protected Health Information (PHI) by Vivify Health & Wellness Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conducting health care operations. I understand I am giving consent to diagnosis or treat me by Vivify Health & Wellness Center, as evidenced by my signature on this document.

____ I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Vivify Health & Wellness Center is not required to agree to the restrictions that I request; however, if Vivify Health & Wellness Center agrees to a restriction that I request, the restriction is binding to Vivify Health & Wellness Center. I have the right to revoke this consent in writing at any time, except to the extent that Vivify Health & Wellness Center has taken action in reliance on this consent. I authorize and give my consent to Vivify Health & Wellness Center to recommend and endorse products and services that it believes may benefit my health care.

____ My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

____ I understand I have a right to review Vivify Health & Wellness Center Notice of Patient Privacy Practices prior to signing this document. The Vivify Health & Wellness Center Notice of Patient Privacy Practices has been provided to me. I have read and understand this notice, and have raised any questions regarding the use of my PHI to Vivify Health & Wellness Center HIPAA Compliance Officer. The Notice of Patient Privacy Practices describes the payment of my bills, or in the performance of health care operations of Vivify Health & Wellness Center. The Notice of Patient Privacy Practices also describes my rights and Vivify Health & Wellness Center obligations with respect to my PHI. Vivify Health & Wellness Center reserves the right to amend the Notice of Patient Privacy Practices. I may obtain a revised Notice by calling the office and requesting a revised copy be sent by mail, or asking for one at the time of my next appointment.

____ By signing this form, I understand that all information shared with the clinicians at Vivify Health & Wellness Center is confidential and no information will be released without my consent. During the course of treatment at Vivify Health & Wellness Center, it may be necessary for my physician, nurse practitioner, medical personnel, and/or other assistants to communicate with other providers at the Vivify Health & Wellness Center. In all other circumstances, consent to release information is given through written authorization. I further understand that there are specific and limited exceptions to this confidentiality which include the following: risk of imminent danger to myself or to another person, suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, or a valid court order is issued for medical records.

____ CONSENT TO GENETIC TESTING: By signing this form, I understand that my health care provider at Vivify Health & Wellness Center may wish to assess the probability that I have an inherited gene for one or more of the following: (1) increased clotting risk, (2) taking or about to take the drug warfarin (Coumadin), (3) inability to metabolize the anticancer drug 5-fluoracil (5FU) and some if its analogues, (4) risk for hyperlipidemia, (5) risk for hypertension, (6) risk for emphysema and liver disease, (7) risk for cardiovascular disease, (8) risk for Alzheimer's disease, or (9) risk for Celiac disease. I understand that Vivify Health & Wellness Center may include genetic testing in diagnostic laboratory testing by blood draw (phlebotomy) for the purpose of discovering genetic risks for developing certain conditions, assisting with a diagnosis, or understanding appropriate therapeutic management. By signing, I understand that each genetic test will only assess for a specific condition and will not detect all of the possible variants of a particular gene, nor will it detect variants of other genes. I understand that the significance of a positive and negative result, the accuracy of a particular test, and the risks and benefits of an ordered genetic test has been reviewed with me. I also understand that the result of a given test may indicate a predisposition to a given condition, which I may consider independent testing if a positive result is obtained, and that a test may fail or be non-informative or non-predictive. I also understand that I have the option to seek genetic counseling prior to signing this informed consent & undergoing any genetic testing procedure.

____ EMAIL/TEXT MESSAGE PRIVACY POLICY: Your email address and text message number will never be used or sold to any third party company besides Vivify Health & Wellness Center. It will be used for two and only two reasons: 1) We will email or text you appointment reminders, and 2) We will email you essential, well-research educational materials, as well as free and discounted offers for medical, massage, chiropractic, health and hygiene products, and/or nutrition. You can unsubscribe from these services as any time.

____ BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM.

Patient's signature_____ **Today's Date**_____

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Patient Consent for use of Protected Health Information (PHI) For Treatment, Payment, & Healthcare Operations (TPO)

Print patient Name:_____ Date of Birth:_____

The payment policy of the office of Vivify Health & Wellness is that payments and copayments are due at the time of service. If we are contracted with your insurance company, you must pay your copay or deductible prior to being seen. As a courtesy, we will submit your insurance claim for you. We will assist you in any way we can to answer your questions you have regarding your insurance plan. It is solely your responsibility to contact your insurance company if they deny payment for any reason. The insurance policy you have is a contract between you and the insurance company. If, for any reason, they do not pay, it is solely your responsibility to make a payment. If the insurance company has not paid a claim within 60 days after the date of service, we will expect payment in full from you. We recommend that you be aware of your benefits prior to being seen in order to prevent any misunderstandings.

Please initial and sign the following:

____ APPOINTMENTS: We try to accommodate our patients in allowing them choices of appointment times. When a patient does not show for the appointment time they scheduled, it has many effects on the practice. In order to continue to accommodate our patients, we feel we must put into policy a fee for all no-shows and any cancelled appointments without 24-hours' notice. A $50.00 (fifty) dollar no show / cancellation fee will be assessed to your account. Your insurance company will not pay for this.

____ INSURANCE RELEASE: I authorize the release of all medical information pertaining to services rendered by Vivify Health & Wellness Center including, but not limited to, billing information, utilization review, and quality assurance. All insurance benefits, including Medicare, for said services may be paid to Vivify Health & Wellness Center.

____ MEDICAL RECORDS: I authorize the release of my medical records by faxing / mailing. I understand that the original record belongs to the treating physician. I may request copies to be sent to anyone I choose. A consent form is available and must be filled out, and records must be paid for prior to the release of said records. A copy of this authorization may be utilized with the same effectiveness as the original.

____ PAYMENT METHODS: (1) CASH is always accepted. Please try to bring small bills to assure that we will be able to make change for you, or we will ask you to use another method of payment. Always request a receipt for your records. (2) CHECKS are accepted with proper ID. If your check does not clear the bank for any reason, your account will be charged a $25.00 returned check fee, and you may incur additional charges for a check recovery agency our office chooses to use. (3) CREDIT CARDS our office accepts Visa, MasterCard, Discover and American Express. (4) CARE CREDIT our office may accept care credit, additional transaction fees may apply.

____ COLLECTIONS: If this Office must take action to collect any outstanding balance on my account, I (patient) will be responsible for payments and will reimburse Vivify Health & Wellness for all costs of such collection efforts, including, but not limited to, all collection fees, court costs and all attorney fees.

Patient's signature_____ **Today's Date**_____