VALEO
HEALTH AND WELLNESS CENTER

Office Use Only
Practitioner: AM DB JT MM RL
Appt Type: CHIRO FUNC MASS
Appt Date _____ ☐ CT ☐ C ☐ Thank You

PERSONAL INFORMATION

Name:	**Guardian's Name (if minor):**		
Today's Date:	**Date of Birth:**		**Age:**
Address:	**Height:**	**Weight:**	**Gender:**
City:	**Email Address:**		
State: **Zip:**	**Ph: H/C**		
Preferred Contact: ◯ Phone ◯ Email	**Do you have MEDICARE?** ◯ Yes ◯ No		
Marital Status (Dropdown):	**Would you like to receive our newsletter?** ◯ Yes ◯ No		

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact	Relationship to Patient	Phone Number

REFERRAL INFORMATION

How were you referred to our office? (Dropdown)

Name of referrer or event (so that we can thank them):

GOALS FOR MY CARE

People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.

◯ Relief Care: Symptomatic relief of pain or discomfort

◯ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

◯ Comprehensive Care: Address the entire system and bring your body to the highest state of health possible.

Any other goals you'd like to share?

THE BEGINNING YEARS

Birth to 17 years of age	NO	YES	EXPLAIN
Did you have any serious childhood illness?			
Did you have any serious falls as a child?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Were you vaccinated?			
Adult: 18 YO to Present			
Are you pregnant? If yes, when are you due?			
Do you have a pacemaker?			
Do you have any metal in your body?			
Do you exercise regularly?			
Do you have any scars?			

HEALTH CONCERNS - List according to severity. Rate from 1 (mild) to 10 (unbearable)

Health Concern	Severity	Episode Start Date?	Had this before? When?	Constant or Intermittent?

Since the problem started, is it (Please Check):

◯ Same ◯ Improving ◯ Worse

Does it travel/radiate?

◯ No ◯ Yes, where?

What makes it better?

What makes it worse?

Do you have a family history of this or similar symptoms?

◯ No ◯ Yes/explain:

Have you seen other doctors for this condition? ◯ No ◯ Yes

☐ Medical ☐ Chiropractor ☐ Other:

If yes, what Yes, diagnosis:

What was done?

Do you have allergies/sensitivities to fragrances or oils?

◯ No ◯ Yes, explain:

Do you have any known allergies?

◯ No ◯ Yes, explain:

How have you taken care of your health in the past?

☐ Medications ☐ Emergency Room ☐ Routine Medical
☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care
☐ Vitamins ☐ Chiropractic ☐ Other:

How have the previous method(s) work out for you?

☐ Bad results ☐ Some results ☐ Great Results
☐ No change ☐ Still trying ☐ Other:

Are you concerned that this condition is or will negatively affect any of the following?

☐ Job ☐ Marriage ☐ Kids ☐ Future Ability
☐ Sleep ☐ Self-esteem ☐ Freedom ☐ Finances
☐ Time ☐ Other

Are you concerned that your helath conditions(s) might turn into any of the following?

☐ Family health problems ☐ Heart Disease ☐ Cancer
☐ Fibromyalgia ☐ Depression ☐ Chronic Fatigue
☐ Diabetes ☐ Arthritis ☐ Other

Have your health condition(s) affected your job, finances, relationships, family or other activities?

☐ No
☐ Yes, explain:

If you have health issues, what have they cost you?

☐ Time ☐ Money ☐ Hope ☐ Happiness
☐ Sleep ☐ Freedom ☐ Please explain:

PAST ACCIDENTS/SURGERIES/INJURIES/PROCEDURES: List all (auto/work), x-rays, trauma (physical/emotional)

Type	Date	Doctor/Hospitalization/x-rays/Procedure

List all prescription drugs, over-the-counter drugs, and all supplements you are currently taking

Name of drug or supplement	Taken for how long?	For what purpose?	How much?

HIPAA ACKNOWLEGEMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Client Name: _____

Signature of patient (or parent, if minor): _____ Date _____

VALEO PAYMENT POLICY

RETURNED CHECK POLICY - If you pay with a check that is returend due to insufficient funds, we will require immediate payment in another form plus a $35.00 returned check fee and any bank charges. If there is no response from you, we must send this to collections.

SERVICE AGREEMENT - I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. Valeo will work with you regarding payment plans if necessary. There will be an 18% APR charged on balances over 30 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

Signature: _____ Date: _____

INSURANCE PAYMENT AGREEMENT - *FOR PERSONAL INJURY, WORK COMP OR MEDICARE ONLY:*
I understand that insurance will be billed for Valeo services and I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature: _____ Date: _____

POLICIES AND PROCEDURES

1. The practitioners design specific health plans in order for you to get better in the shortest amount of time. It is to your benefit to maintain your visit schedule and care plan as explained to you in the Report of Findings. The practitioners take your health very seriously and we ask that you do the same.

2. If you need to cancel or reschedule an appointment, please provide the office with at least a 24-hour notice. Our goal is to stay on time; however, occasionally emergencies or unforseen circumstances arise where the practitioner will spend more time with a patient. We will do our best to inform you if the practitioner is running behind schedule.

DIRECTIONS: On a scale from 1-10, where (10) is the highest and (1) is the lowest, please rate your current "health level" in each significant area of your life.

Relationship / Family Life

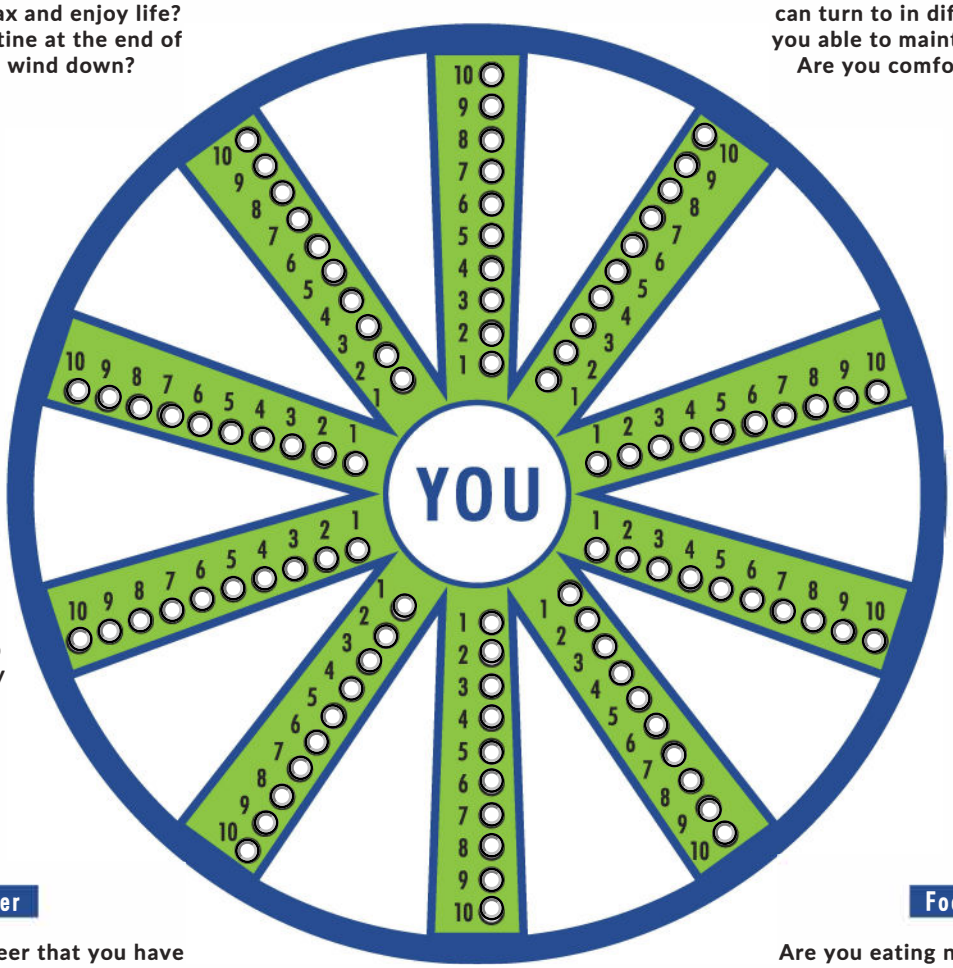
Are you in a loving relationship? Do you feel like you spend enough quality time with your family? Do you have a close connection with your children, parents, and relatives? Do you have poor family relationships from the past or present that negatively impact your health?

Leisure

Are you taking regular vacations without bringing work with you? Do you have time set aside each week to relax and enjoy life? Do you have a healthy routine at the end of the day that helps you wind down?

Social Health

Do you have a connection with at least one other person, outside your family, who you can turn to in difficult and good times? Are you able to maintain long-term friendships? Are you comfortable in social settings?



Environmental

Do you regularly enjoy time out in nature? Do you spend time doing outdoor activities such as sports, camping, fishing, hiking, etc.? Are you aware of toxins in your environment? If you are aware of certain environmental toxins, do you limit your exposure to them?

Intellectual

Are you open to new ideas? What is the quality of the information and entertainment that you allow into your mind? Do you challenge yourself to learn new things and hobbies?

Spiritual

Do you feel that you have a close/strong relationship with God? Do you regularly study, meditate, pray or worship? Do you regularly attend fellowship with others whom share the same beliefs as yourself?

Physical

Do you have plenty of energy? Do you exercise, eat healthy and drink plenty of water on a regular basis? Are you limited in what you can do because of physical ailments?

Job / Career

Are you working in the career that you have always wanted to be working in? Does your job stimulate you, give you energy or drain your energy? Does your career allow you to live the lifestyle you desire? Are you working in a position or towards a career that you feel God has planned for you?

Food / Nutrition

Are you eating natural/organic foods? Are you skipping meals? Do you plan out your meals ahead of time? Do you take whole-food supplements?

Psychological / Emotional / Stress

Do you have a positive attitude even during stressful times? Does your stress level overwhelm you? Do you have peace in your life?

Name:

Date:

SCORE:

Your Well Score

1. Copy your score from the front and write it here _____ / 100.

2. Knowing the score you wrote down, what would you like your total score to be?_____

3. What do you think the time frame will be to achieve that number? _____

4. Of the ten categories on the front, what area of your life would you like to change the most?

_____

5. What changes in your life do you think will need to be made in order for you to achieve your goal(s)? Please check all that apply below.

☐ Exercise ☐ Diet Changes ☐ Supplements ☐ Body Cleanse ☐ Chiropractic Care

☐ Massage Therapy ☐ Medical Treatment ☐ Counseling ☐ Spiritual Healing

☐ Other _____

6. How will your life improve as a result of making these changes?

_____

_____

_____

_____

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