Bella Vita Chiropractic & Wellness
610 Eastbury Drive Suite 3 Iowa City, IA 52245 (319) 887.6992

Patient Data **Date:** ______________

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

First Name: ____________________ **Middle Initial:** ____ **Last Name:** ________________________

Address Line 1: ____

Address Line 2: ____

City: ________________________________ **State:** ________ **Zip Code:** ____________________

Home Phone: (______)________-______________ **Work Phone:** (______)________-______________

Cell Phone: (______)_________-______________

Date of Birth: ______/______/_______ **Sex:** ☐Male ☐Female **Email:** ____________________________

Social Security Number: _______-______-___________ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No **Spouse's Date of Birth** ______/______/_____

First Name: _______________ **Middle Initial:** ___ **Last Name:** ___________________________

Home Phone: (______)_______-______________ **Work Phone:** (______)_________-______________

Employer Data

Name: ____

Address Line 1: ____

City: __________________________________ **State:** _________ **Zip Code:** ___________

Emergency Contact **Physician's Name:** _________________________

Contact Name: ____

Contact Phone: (________) _________-______________

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Is it okay to call you at work?
❑ Yes ❑ No

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

____________________ ____________________ ____________________ ____________________

If you selected 'family member', 'friend', or 'physician' please enter their name below:

____

If you selected 'other' please describe

____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionall	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Female Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor

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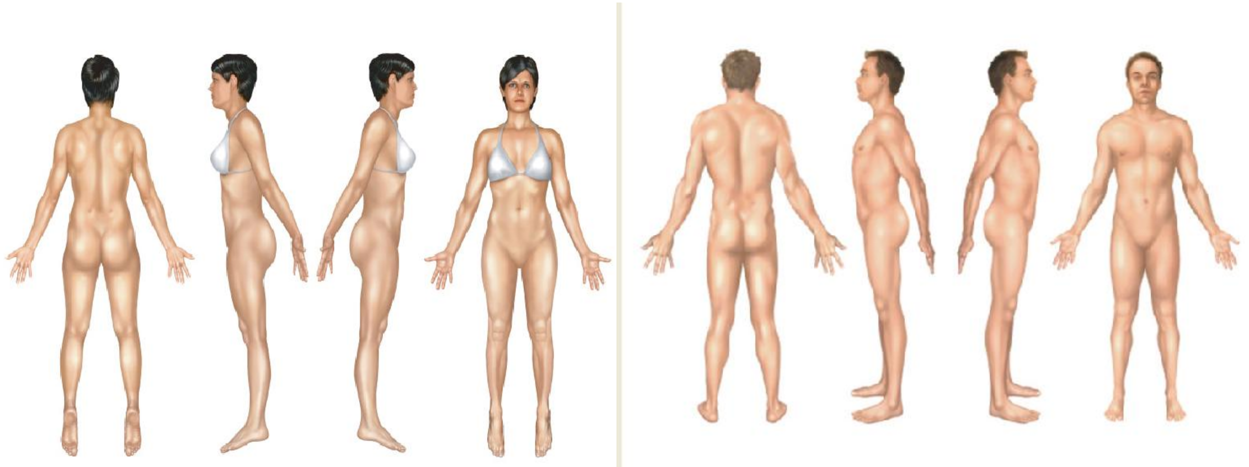
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:____

____

____

When did your symptoms start? **Month**______________________ **Day**_________________ **Year**________________

How did your symptoms begin?____

____

Patient Health Information Consent Form

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We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

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Informed Consent

The primary treatment used by doctors of chiropractic is the spinal manipulation or spinal adjustment.

- **The nature of the chiropractic adjustment:**

  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This adjustment my cause an audible "pop" or "click" much like when you "crack" your knuckles. You may or may not feel or sense movement.
- **The material risks inherent in chiropractic adjustments:**

  As with any healthcare procedure, there are certain complications which may arise during a chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
- **The probability of risks occurring:**

  Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and physical examination or x-rays is medically necessary. Stroke has been the subject of tremendous disagreement within and without the profession; however, the fact remains that the incidence is extremely rare. Despite the rarity of the occurrence of a stroke we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.
- **The risks and dangers attendant to remaining untreated**
- Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read or have had read to me the above explanation of the chiropractic and adjustment and related treatment. I have discussed it with Dr. Jordan M. DeGrazia and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to receive care.

Date: ___________ **Printed Name:** ___________________________________

Signature: ______________________________________

Signature of Parent or Guardian: ____________________