



New Patient Intake Form

Date: _____

Welcome to Vitality Healthcare PC! This is your New Patient information packet. Please take the time to read, fill out, and sign the appropriate sections. Please plan to arrive 15 minutes prior to your scheduled appointment time as this allows us to better take care of your needs. If you wish to cancel or reschedule your appointment, please contact our office **24 hours or more in advance**. It is our goal to provide each of our patients the best care possible. If you feel you have been treated otherwise, please let us know.

What are your most important health concerns and how long have you had each concern?

Condition	How long?
1.	
2.	
3.	
4.	

Pain Assessment

Please rate your level of **pain 1-10** = Highest _____ To what do you attribute your pain? _____

Please indicate the **type of pain** you are having:

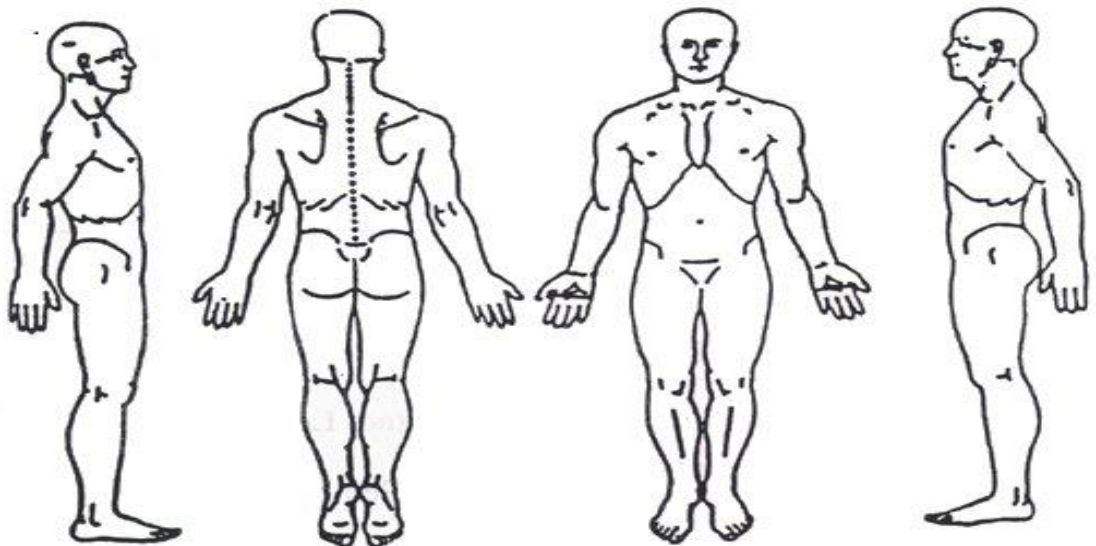
Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

Is your pain the result of an auto or work injury? _____ If so, when? _____

Do any movements/positions/activities make the pain **better or worse**?

Please describe, if applicable, any ways in which your pain **interferes with your daily activities**.

Please place an "X" on the area or areas that best show the location(s) of your pain.



Please mark each of the following symptoms with "1" if you have the problem *now/currently*; OR mark "2" if you've had the *problem in the past*.

General

- Weight gain
- Weight loss (without cause)
- Headaches
- Fatigue
- Fever
- Difficulty sleeping
- Anxiety
- Depressed moods
- Dizziness

Muscles/Joints

- Low back pain
- Neck pain/stiffness
- Knee pain
- Shoulder pain
- Hip pain
- Foot trouble/pain
- Muscle weakness
- Numbness/pain
- Arm/leg/hand pain

Gastro-Intestinal

- Frequent heartburn
- Chronic use of PPIs
- Stomach pains
- Belching or gas
- Nausea
- Vomiting with meals
- Diarrhea
- Constipation
- Hemorrhoids
- Blood in stool

Cardio-Vascular

- Heart palpitations
- Chest pains
- Ankle/leg swelling
- Poor circulation
- Varicose veins
- Cold hands/feet
- Easy bruising

Respiratory

- Chronic cough
- Bloody sputum
- Chronic phlegm
- Wheezing
- Difficulty breathing

Genito-Urinary

- Frequent urination
- Painful urination
- Blood in urine
- Kidney stones
- Bed wetting
- Incontinence
- Erectile dysfunction
- Prostate trouble

Skin/Allergies

- Acne
- Rash
- Dryness
- Frequent boils
- Irregular mole

Eye/Ear/Nose/Throat

- Changes in vision
- Pain in eyes
- Hearing loss
- Earache
- Ringing in ears
- Frequent colds
- Frequent sore throat
- Frequent sinusitis
- Seasonal allergies
- Enlarged thyroid

Women Only

- Painful periods
- Heavy menses
- Irregular cycles
- Hot flashes
- Cramps
- Vaginal discharge
- PMS

Last menstrual cycle:

___/___/___

Date of last PAP:

___/___/___

Date of last Mammo:

___/___/___

Please mark exposure history:

- Mononucleosis
- Polio
- Rheumatic fever
- Measles
- Influenza
- Root canal
- Mercury fillings
- Mold exposure
- Chemical exposure
- Tuberculosis
- Vaccinations
- Mumps
- Whooping cough
- Chicken pox/Shingles

Reviewer Notes:

Habits/ Lifestyle

Patient Last Name, First Initial _____

Vitality Healthcare - New Patient Intake

Do you use tobacco? **Current Everyday** **Some Days** **Former smoker** **Never**

Use alcoholic beverages? **None** **Occasionally** **Frequently** **Daily** **History of Alcoholism**

Do you eat Healthy meals **Y N**

Are you following any special Diet? Gluten free / Paleo / Dairy free / Vegetarian / Vegan / Other _____

Have you dieted recently and if so, how much weight did you lose? _____

Tell us everything you've eaten in the last 24 hours (breakfast, lunch, dinner, snacks)

Do you exercise regularly? **Y N** If yes, what kind/how often _____

Do you drink coffee Daily? **Y N** Do you drink soda/pop regularly? **Y N**

Occupation? _____ Do you enjoy your work? **Y N**

Please rate your energy level on average (10 is best). 1 2 3 4 5 6 7 8 9 10

Please rate your stress from 1-10 (10 highest). 1 2 3 4 5 6 7 8 9 10

Hours of sleep each night? _____ Sleep well? **Y N** Awake rested? **Y N**

Have a supportive relationship? **Y N** Have a religious/spiritual practice **Y N**

Past Medical History

Condition/Disease	Year Began	Condition/Disease	Year Began
___ Cataracts		___ Nephrolithiasis (kidney stone)	
___ Wear glasses/contacts		___ Arthritis	
___ Hearing Aids		___ Gout	
___ Allergic Rhinitis/ seasonal allergy		___ Dermatitis/ Chronic Rash	
___ DVT (blood clot)		___ Psoriasis	
___ Hypertension		___ Epilepsy	
___ Murmur of Heart		___ Severe Headaches/ Migraines	
___ MI (heart attack)		___ Stroke	
___ Asthma		___ Bipolar	
___ COPD or Emphysema		___ Depression	
___ Cirrhosis		___ Hyperlipidemia/ Cholesterol	
___ GERD/ Heart Burn		___ Thyroid disease	
___ Stomach Ulcers		___ Hashimotos	
___ Hemorrhoids		___ Diabetes ___ Type 1 ___ Type 2	
___ Incontinence		___ Cancer Type _____	

Family History

	Father	Mother	Siblings	Maternal Grandparents	Paternal Grandparents
Age if living:					
Age when Died:					
Reason for Death:					

No Health Concerns					
Arthritis					
Asthma					
COPD					
Diabetes					
Heart disease					
Hypertension					
Mental illness					
Other:					
Cancer, type:					

Doctor, Hospitalization, Surgery, Imaging

Primary Care Physician (name and phone #) _____

Surgical History:

Surgery/Procedure	AGE of Surgery	Reason Performed/Result
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any recent Bloodwork completed? Y N Location of results _____

Have you had any recent Imaging completed? Xrays MRI CT Ultrasound Other _____

(Please bring us a paper copy of any pertinent recent blood work or imaging with you to your first medical appointment.)

Allergies

Any drug allergies? _____ **If yes, please explain reaction:** _____

Are you hypersensitive to:

Any foods? _____ If yes, explain: _____

Any chemicals or substances in the environment? Y N If yes, explain: _____

Have you ever had allergy testing completed? Y N

Current Medications/Supplements

Prescription Medications:

Medication	Length of time	Dose	Frequency
Ex. Atenolol	1 yr	20 mg.	1x per day PRN
1.			
2.			
3.			
4.			
5.			
6.			

Vitamins/Supplements:

Over the Counter Medications (i.e Motrin, Benadryl, etc.)

** Please list additional medications/supplements on the back

The following questions will help us understand your expectations.

1. Why did you choose to come to Vitality Healthcare?

2. What aspect of a holistic / nutritional approach appeals to you?

3. As the process of assessment, planning, intervention, and follow-up progresses, how will you know you are getting better? What will you be able to do that you can't do now?

4. What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle? (Rate 1-10 = 100% committed)

1 2 3 4 5 6 7 8 9 10

5. What lifestyle habits do you currently engage in that you believe support your health?

6. What lifestyle habits do you currently engage in that you believe harm your health?

7. What beliefs/obstacles do you foresee that could undermine your progress?

8. What else is important to you that we (the Vitality Healthcare doctors and staff) should be aware of as we begin working together?

Demographic Information

Full Legal Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Gender: M F

Telephone # (Home): _____ (Work): _____ (Cell): _____

Email Address: _____ Date of Birth: _____

Age: _____ If under 18, Guarantor: _____

Marital Status: Married Separated Divorced Widowed Single # Children _____

Occupation: _____ Hours per week: _____ Retired:

Employer: _____ Work Address: _____

How did you hear about Vitality Healthcare PC and/or who can we thank for referring you?

Have you attended Dr. Osterhout’s “Health Solutions Seminar”? _____ **Date Attended:** _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Address: _____ Phone: _____

Do you have health insurance?: Yes No Name of Carrier: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder’s Employer: _____

Policy Holder’s relationship to patient (if other than self): _____ Phone: _____

Policy Holder’s address: _____

Insurance Contract ID #: _____ Group #: _____

Your relationship to policyholder: ___Self ___Spouse ___Child ___Other

Do you have secondary insurance?: Yes No Name of Carrier: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder’s Employer: _____

Policy Holder’s relationship to patient (if other than self): _____ Phone: _____

Policy Holder’s address: _____

Insurance Contract ID #: _____ Group #: _____

Your relationship to policyholder: ___Self ___Spouse ___Child ___Other

** Please provide the front desk with copies of all insurance cards

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY**

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay Vitality Healthcare as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20 _____.

X _____
(Patient Signature)

(Please Print Patient Name)

X _____
(Signature of Guardian, if applicable)

Informed Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities; which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, claims or disputes will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the above consent form.

Sign here: X _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Vitality Healthcare.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of the Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and that the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves as a notice that as part of our effort to deliver the most consistent healthcare we can to every patient. We use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X _____
Signature of Patient/Guardian

Date

X _____
Witness (Office Staff)

Date

Patient Name: _____