VITAL
WELLNESS CENTER
AUTO AND SPORTS INJURY SOLUTIONS

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex: F ☐ M ☐

Address _____ City _____ Zip _____

Last 4 # SS_____Home Phone _____ Cell Phone _____ E-Mail _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

Other doctors or therapist who has treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

434 NW Lake Whitney Place
Port St Lucie FL 34968
(772) 232-4091 ♦ Fax (772) 232-4092
www.vitalwellnesscenter.com

COVID 19 PROTOCOLS

Vital Wellness Center is committed to serving our patients in a safe environment. During the COVID-19 (Novel Coronavirus) pandemic we remain vigilant in our efforts to provide personal, progressive and uncommonly effective treatment, as long as we can do so within the recommendations, guidelines and best practices set forth by the CDC, Florida Department of Health, and the Federal, State and County governments.

It is our intention to remain available to our community for treatment of acute pain, chronic pain, sports, auto accident and other injuries. At this time, we are also continuing our work with all patients who want to improve their experience and live the Movement Lifestyle.

The following protocols will remain in effect until further notice:

- Our staff will call to review patient's general health status, history of acute respiratory symptoms including cough, shortness of breath or fatigue and fever.
- Patients with any condition causing increased risk from COVID-19 will be asked to cancel their appointments.
- Absolute strict standards of sanitary operation will be followed, including cleaning of all surfaces that may be contacted by patients or staff. This will be done before every patient encounter.
- Standard Precautions remain in effect. We assume that every person is potentially contagious with the virus that causes COVID-19.
- We will ask all our patients to refrain from brining any other children or adults to their appointments unless absolutely necessary.

Vital Wellness Center will monitor the situation constantly. Should any Federal, State or County government agency mandate the closure of our office will do so immediately. Should it become apparent at any time that our measures cannot protect our community, patients, and staff from infection, we will close. Thank you for understanding.

_____Initials

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Dear Valued Patient:

Vital Wellness Center values your time. We know that we each have busy lives and we appreciate your commitment to the treatment process. Please know that each visit is important and will lead to the most efficient and long-lasting improvement.

Vital Wellness Center respects appointment times and never "double-books" appointments. In order to stay on-schedule we will commit to the following:

1. We will never shorten appointments. The Doctor and Active Care Associate will fully dedicate the entire time to you. Sometimes, in complicated cases or when patients travel long distances to meet with us, we will be happy to schedule extra time. Extended time is offered at a discounted rate.
2. We will make every effort to see you at your scheduled time. Arriving a few minutes early will allow us to attend to any procedural or administrative tasks before your appointments. Please arrive on time for each appointment.
3. Early arrival: we appreciate punctuality and early arrival. If you arrive early, we will do our best to see you early if doing so does not interfere with other patient appointments.
4. Late arrival: We know, life sometimes throws a curve ball. If you arrive late, even a few minutes late, we will make every effort to see you anyway, if doing so does not interfere with other patient appointments. We cannot rush or shorten appointments due to late arrival.

By following these simple guidelines, we respect the appointment time of all of our patients. Thank you for understanding.

Sincerely,

The Vital Wellness Team

_____

Please Initial

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Informed Consent:

Chiropractic care is usually safe. The doctor may use his hands to help move joints in your body when deemed necessary. Various ancillary procedures, such as hot and cold packs, massage therapy, electrical stimulation, therapeutic ultrasound or traction and exercise may also be used.

To delay treatment may allow formation of adhesions, scar tissue and other degenerative changes to develop. These changes can further reduce general skeletal mobility which will induce the likelihood of chronic pain cycles. It is quite probable that the delay of treatment will complicate a condition and make future rehabilitation more difficult. As with any health care procedure, complications are possible although unlikely resulting in various adverse reactions.

Chiropractic manipulations although extremely rare, have led to the possibility of cerebral vascular disorders, ie: stroke. It has been estimated that approximately one in one million to one in twenty million, and can be reduced further with various screening procedures. A small percent of patients may notice temporary stiffness or soreness after the first few days of treatment. The possibility of adverse reactions to ancillary procedures is considered extremely rare although may cause various skin reactions producing minor complications.

Other treatment options which could be considered may include over the counter medication, medical care, hospitalization and surgery, all of which are considered less conservative treatment options.

I have fully evaluated the risks and benefits of undergoing treatment and I freely decided to undergo the recommended treatment and hereby give my full consent to undergo chiropractic management.

_____ _____

Patient's or Child's Name (Print) Parent or Guardian Signature

_____ _____

Patient's Signature Parent or Guardian Name

_____

Date

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Please Print Name:_____

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

_____ DATE_____

SIGNATURE OF PARTICIPANT

_____ DATE_____

SIGNATURE OF WITNESS

RESEARCH CONCERNING THE REHABILITATION PROGRAM AND RESULTS MAY BE CONDUCTED. DATA WILL BE USED FROM THE PARTICIPANT'S EVALUATIONS AND EXERCISE PROGRAM. NO NAMES WILL BE USED AND ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INITIAL BELOW.

_____ I AGREE TO PARTICIPATE _____ I DO NOT WISH TO PARTICIPATE

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Dr. Brandon Levenick

Exception to the Release of Protected Health Information (PHI)
For Vital Chiropractic Wellness Center

Patient Name: _____ Date of Birth: _____
Last 4 digits SS#: _____
Address: _____
_____
Phone Number: _____

Exception for Disclosure (Individuals or means where by P.H.I. may be released)
I authorize the following people to the involved in my care that may require a disclosure of PHI.

Individual's Name (Please Print)	*Relationship to Patient*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient (or Legal Representative) Date of Request

FOR PRACTICE USE ONLY

_____ _____

Signature of Employee Receiving Request Date Received

Request for exception has been Approved / Denied Reason for denial:

_____
_____
_____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____