Re-Exam Intake/New Injury

Your name | Today's Date (mm/dd/yyyy) | Your Age

☐ I have new contact information

Referring/Primary Physician

1. Is this due to a: ☐ Car Accident ☐ Work injury ☐ Personal injury ☐ Other: _____

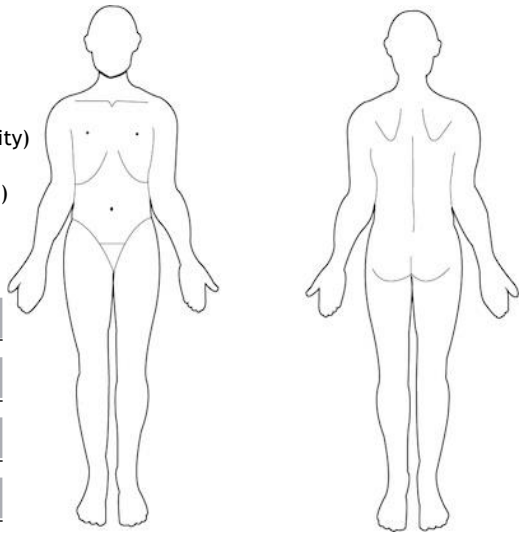
2. List your current complaints using the keys below.

- **Indicate the area/complaint.**
- **Mark the average and worst intensity**
- **Mark the frequency.**
- **Mark the circles according to "quality" (the sensation)**

Key:

- **Intensity** (0-10): 0 -> none /10 -> highest conceivable intensity)
- **Frequency:** (1-4):

(1) Occasional (0-25% of time) (2) Intermittent (26-50% of time)
(3) Frequent (51-75% of time) (4) Constant (76-100%)



		Ave. Pain	Worst Pain	Freq.
1.				
2.				
3.				
4.				

☐ Throbbing ☐ Numbness ☐ Nagging ☐ Soreness ☐ Swollen ☐ Tightness ☐ Cramping
☐ Achiness ☐ Tingling ☐ Burning ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Stabbing

3. Review of systems (identify any changes since your most recent evaluation with us)

	Worse	No Change	Better
a. Neurological System – Such as numbness, tingling, balance, dizziness, etc	☐	☐	☐
b. Cardiovascular System – Such as heart, blood pressure, circulation, etc	☐	☐	☐
c. Respiratory System – Such as lung, allergies, breathing, etc	☐	☐	☐
d. Digestive System – Such as stomach, digestion, colon, etc	☐	☐	☐
e. Sensory System – Such as eyes, ears, smell, taste, etc	☐	☐	☐
f. Integumentary System – Such as skin, hair, nails, etc	☐	☐	☐
g. Endocrine System – Such as thyroid, infection, swollen glands, etc	☐	☐	☐
h. Genitourinary System – Such as kidney, bladder, prostate, etc	☐	☐	☐
i. Constitutional System – Such as appetite, fatigue, weight change, etc	☐	☐	☐

4. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Work duties	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Gardening/Yard work	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Athletics/Recreation	☐	☐	☐	☐

Office Use Only

5. Illnesses, surgeries, injuries since your most recent evaluation with us: ☐ YES ☐ NO

6. Have you seen any other healthcare providers or had any diagnostic tests since last evaluation?: ☐ YES ☐ NO

7. Changes in medications/supplements? ☐ YES ☐ NO

Has your insurance changed in the last year? ☐ Yes ☐ No (if yes, please see front desk staff)

Has your address changed in the last year? ☐ Yes ☐ No (if yes, note below)

Mailing address

E-mail address

City | State/Province | ZIP/Postal Code | Cell phone | ☐ OK to leave Voicemail?

Emergency contact name | Relationship | Telephone

Family/Specialist Doctor (if applicable)

Primary care physician (Family doctor) | Clinic | Telephone | Fax

If you would prefer us to NOT communicate with your PCP regarding care, mark "No" and initial: ☐ No Initials: _____

Informed Consent – To be completed by patient

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, acupuncture, trigger point injections, diagnostic x-rays, diagnostic ultrasound, diagnostic lab work including urine, blood, gynecological specimens and body cultures, medical doctor and/or chiropractic manipulations on me (or the patient named below, for whom I am legally responsible) by any licensed clinicians who, now or in the future, treat me while employed by, work or are associated with, or are serving as a replacement or locum, for any Vida Integrated Health clinic, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the clinicians, and/or with other office or clinic personnel, the nature and purpose of all recommended procedures.

I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, acupuncture, naturopathy and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the Vida clinician to be able to anticipate and explain all risks and complications, I wish to rely on the Vida clinician to exercise judgment during the course of the procedures which the Vida clinician deems necessary and, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to evaluation and treatment at Vida. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature Date: _____

Patient Printed Name

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

_____ Date _____

Representative Signature

_____

Representative Name