



FLORIDA COAST
CHIROPRACTIC CLINIC

PATIENT DATA:

DATE: _____

Title: (Circle one) MR. MRS. MS. MISS DR. OTHER _____

FIRST NAME: _____ **LAST NAME:** _____

I go by _____

ADDRESS : _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: (____) _____ - _____ **CELL PHONE:** (____) _____ - _____

EMAIL: _____

DATE OF BIRTH: ____/____/____ **GENDER:** ___ MALE ___ FEMALE

MARITAL STATUS: ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ OTHER

EMPLOYMENT STATUS: ___ EMPLOYED ___ UNEMPLOYED ___ RETIRED ___ OTHER
_____ FT STUDENT _____ PT STUDENT

OCCUPATION: _____

EMPLOYEER: _____

ADDRESS: _____

PHONE #: _____

EMERGENCY CONTACT:

NAME: _____ **RELATIONSHIP :** _____

* **CONTACT HOME PHONE:** (____) _____ - _____ **CELL PHONE:** (____) _____ - _____

PATIENT NAME _____ DATE _____

MEDICAL CONDITIONS: (Check all that apply to you)

- | | |
|--|--|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> PSYCHIATRIC ILLNESS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> SKIN DISORDER |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> STROKE |

OTHER _____

SURGERIES: (Check all that apply to you)

- | | | | |
|---|--|----------------------------|----------------------------|
| <input type="checkbox"/> APPENDECTOMY | <input type="checkbox"/> BRAIN | | |
| <input type="checkbox"/> CARDIOVASCULAR PROCEDURE | <input type="checkbox"/> SHOULDER | | |
| <input type="checkbox"/> CERVICAL SPINE | <input type="checkbox"/> THORACIC SPINE | | |
| <input type="checkbox"/> HYSTERECTOMY | <input type="checkbox"/> KNEE | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> JOINT REPLACEMENT | <input type="checkbox"/> CARPAL TUNNEL | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> PROSTATE | <input type="checkbox"/> GASTRO-INTESTINAL | | |
| <input type="checkbox"/> LUMBAR SPINE | <input type="checkbox"/> URO-GENITAL | | |
| <input type="checkbox"/> GALL BLADDER | <input type="checkbox"/> HERNIA | | |

OTHER _____

ALLERGIES: (List any allergies you have)

SOCIAL HISTORY: (Check all that apply to you)

- Caffeine use: occasional _____ often _____ never _____
Drink Alcohol: occasional _____ often _____ never _____
Exercise: occasional _____ often _____ never _____
Tobacco Use: occasional _____ often _____ never _____
Sleep: Hours per night _____
Stress Level: High _____ Moderate _____ Low _____ None _____

FAMILY HISTORY: (Check all that apply)

- | | <u>PARENT</u> | <u>SIBLING</u> |
|----------------|---------------|----------------|
| Arthritis: | _____ | _____ |
| Cancer: | _____ | _____ |
| Diabetes: | _____ | _____ |
| Heart Disease: | _____ | _____ |
| Stroke: | _____ | _____ |
| Thyroid: | _____ | _____ |

OTHER _____

REVIEW OF SYSTEMS: (Check only symptoms you've had trouble within the last 3 months)

GENERAL:

- Weight Change
- Fever
- Chills
- Night Sweats
- Weakness
- Fatigue

Skin:

- Rash
- Itching
- Hair Changes
- Nail Changes

Cardio:

- Murmur
- Chest Pain
- Palpitations
- Difficulty Breathing
- Wheezing
- Blue Extremities
- Swollen Extremities

Eyes:

- Vision
- Pain
- Discharge

Neurologic:

- Headache
- Dizziness
- Fainting
- Convulsions

Breasts:

- Mass
- Pain
- Discharge
- Self-Exam

Ears:

- Hearing
- Ringing
- Pain
- Discharge

G.I.:

- Appetite
- Abdominal Pain
- Vomiting
- Diarrhea
- Constipation

Psychologic:

- Anxiety
- Depression
- Moods
- Memory

Nose:

- Pain
- Bleeding
- Taste

G-U:

- Frequent Urination
- Painful Urination
- Incontinence

Musculoskeletal:

- Neck
- Upper Extremities
- Upper Back
- Lower Extremities
- Lower Back

Mouth / Throat:

- Sores
- Bleeding
- Taste

ADDITIONAL INFO:

Please list **ALL** current medications and/or supplements being taken:

PATIENT NAME _____ DATE _____

Are you pregnant? _____ Yes _____ No _____ N/A

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

X - ACHING

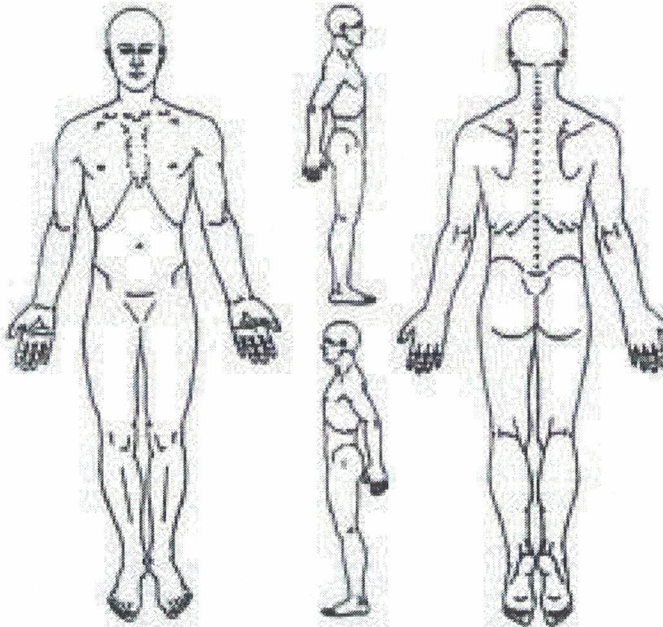
^ - BURNING

~ - SPASM

O - PINS & NEEDLES

\ - STABBING

< > - NUMBNESS



On an average rating from 0-10, how much pain are you experiencing: 0=no pain and 10= the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

(FOR OFFICE USE ONLY)

O
P
P
Q
R
S
T

ACTIVITIES OF DAILY LIVING:

Please circle if you have pain or difficulty performing the following:

- | | | |
|-----------------------|---------------------|-------------------------|
| Bending | Carrying Groceries | Household Chores |
| Driving | Sitting to Standing | Kneeling |
| Extended Computer Use | Climbing Stairs | Reading (Concentration) |
| Lift Children | Lifting | Pet Care |
| Self Care - Bathing | Walking | Sexual Activities |
| Self Care - Dressing | Sleep | Yard Work |
| Prolonged Sitting | Prolonged Standing | Other _____ |

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes _____ No _____ Date: ____/____/____
Time: _____ a.m. / p.m.

If work is responsible, please fill out the following:

Employer: _____
Your occupation: _____
Job description: _____
Address: _____
City: _____
State: _____ Zip Code: _____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

PRIMARY CARE PHYSICIAN: _____

PCP PHONE # (____) _____ - _____ ADDRESS: _____

WOULD YOU LIKE FOR US TO SEND OFFICE NOTES TO YOUR DOCTOR: _____ YES _____ NO

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and / or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date _____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care:

_____ Date _____

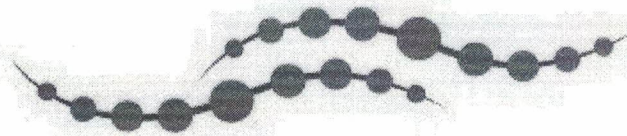
******* CANCELLATION POLICY*******

We are very pleased to participate in your healthcare, and have set aside time for your appointment.

We understand that sometimes it is necessary to cancel or change an appointment. In consideration of others who need care, we ask that if you are unable to keep your appointment with our office, please let us know as soon as you can, either by phone, email, or by replying to the text notification.

If you are unable to do this, you will be billed a \$25 no-show fee.

_____ *please initial here to acknowledge reading policy. Thank you!*



FLORIDA COAST
CHIROPRACTIC CLINIC

CONSENT FOR CHIROPRACTIC CARE

One treatment I use as a Dr of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

As a patient coming to Florida Coast Chiropractic Clinic, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis and analysis.

The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known whatever he/she is suffering from: defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides specialized non-duplicating healthcare service.

Your Chiropractic Physician is licensed in a special practice and is available to work with other types of providers in the healthcare regime.

"I understand if I am accepted as a patient by a physician at Florida Coast Chiropractic Clinic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon request."

Dated: _____

(Please print patient name)

(Patient signature)

(Signature of Parent or Guardian)

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Florida Coast Chiropractic Clinic, Inc. on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Florida Coast Chiropractic Clinic, Inc. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Florida Coast Chiropractic Clinic, Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party

Date

Print Name of Patient, Authorized Representative or Responsible Party