PATIENT INFORMATION

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

Todays Date

Name SS No

Address Apt No

City St Zip

Home Phone No Cell No Work No

Emergency Contact? No

May We Send You Health Information Via Email? YES NO

Email Address

Employer

Occupation

Duties/daily Activities @ Work

Best Way To Contact You? Home Work Cell

Sex M F Marital Status S M D W

Age Date Of Birth

Reason For Coming In Today?

How Did You Hear About Us?

How Long Ago Did the Pain Start?

Previous Chiropractor's Name

Last Visit Results?

Are You Pregnant? YES NO Due Date

Date of Last Exam

Reason for Exam

PAST ACCIDENTS, FALLS, INJURES, TRAUMAS OR SURGERIES

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Please List Any Past Accident, Falls, Injuries, Major Illness, Traumas Or Surgeries

Date: What Happened?

Date: What Happened?

Are You Presently Taking any Medications? YES NO

Name of Drug: Amount:

Name of Drug: Amount:

Please check any of the following that give you difficulty:

Headaches	Stress	Flatulence / Gas	Hot Flashes
Head Feels Heavy	High Blood Pressure	Acid Reflux / Heartburn	Night Sweats
Heart Pain	Loss of Taste	Irregular Sleep	Indigestion
Menstrual Cramps	Ulcers	Wake up in Middle of Night	Shooting Head Pain
Muscle Spasms	Thyroid Trouble	Dizziness	Anemia
Tingling / Numb. of Hands	Fatigue	Heart Palpitations	Diabetes
Can't Get Back to Sleep	Sinus Pain	Menstrual Issues	Twitching of Face
Intestinal Gas	Tightness in Throat	Nervousness	Chest Pains
Low Back Pain	Grating Noise Neck	Ringing in the Ears	Liver Trouble
Mid Back Pain	Swelling	Arms / Hand Pain	Allergies
Fainting	Nervous Stomach	Irritability	Leg / Feet Pain
Loss of Balance	Tight Muscles	Cold Hands	Shortness of Breath
Heart Attacks	Arthritis	Cold / Heat Intolerance	Neck Pain
Constipation	Bloated After Eating	Hay Fever	Cold Sweats

Any Family members experiencing any of the above difficulties?

Whom? Which?

Family History of disease?

Whom? Which?

Hours of Sleep per Night? Is Your Sleep Interupted?

INFORMED CONSENT FOR CHIROPRACTIC CARE

(PATIENT AND DOCTOR AGREEMENT)

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When a patient seeks chiropractic health care and we accept a patient for care, it is essential that both the patient and doctor to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risk, and alternatives. Our office's policy is as follows: "Your body, Your, Health, Your Choice." We will recommend what we feel is the best health care advice for you; however, it is your choice to do what you want with that advice whether it be to utilize our recommendations or to seek other means of health care for your condition.

CHIROPRACTIC has only one goal, the detection and correction of the VERTEBRAL SUBLUXATION. Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of HEALTH.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease, signs or symptoms.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Vertebral Subluxations are corrected and/or reduced by an adjustment. An ADJUSTMENT is the specific application of forces via hand or instrument to facilitate the body's correction of the vertebral subluxation. Our method of correction in this office is by specific adjustments utilizing the hands or an instrument as well. In addition, ancillary procedures such as physiotherapy and /or rehabilitative procedures may be included or recommended.

We do not offer to TREAT ANY DISEASES! We detect and correct vertebral subluxations as well as identify stresses the body may have on it that may limit its ability to function. We may recommend additional ancillary procedures that may benefit the reduction of these stresses however we DO NOT AND WILL NOT TREAT INDIVIDUAL DISEASES, NOR MAKE THAT CLAIM. We may have patients with certain diseases; however we treat the patient by removing and/or reducing the vertebral subluxation and their stress, not the DISEASE. If during the course of our care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider that may specialize in that area.

Like most health care procedures, the chiropractic adjustment carries with it some risks. The POSSIBILE RISKS may include temporary soreness or increased symptoms of pain. (It is not uncommon for patients to experience temporary soreness or increased symptoms of pain after the first few treatments). Dizziness, nausea, flushing, as well as fractures, may occur (These symptoms are relatively rare). When a patient has underlying conditions that may weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. Treatment plans will be modified accordingly. Spinal conditions like a disc herniation or bulge can potentially worsen with chiropractic care, however we take a very gentle approach to such conditions and oftentimes treatment is extremely effective. A certain extremely rare

type of stroke/cerebro-vascular injury can be associated with chiropractic care. This occurrence has been estimated at one in one million to one in twenty million but often even further reduced by cardiovascular screening procedures by our office. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices.

I understand that the practice of chiropractic, like the practice of all healing arts and medicine, is not an exact science, and I acknowledge that no guarantees can be given as to the results or outcome of my care.

OTHER TREATMENT OPTIONS which could be considered may include the following:

Over-the counter analgesics: The risks of these medications include irritation of the stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization: in conjunction with medical care adds risk of exposure to virulent communicable diseases.

Surgery: in conjunction with medical care adds the risk of adverse reactions to anesthesia, as well as an extended convalescent period.

RISKS OF REMAINING UNTREATED: Delay of treatment allows a formation of adhesions, scar tissue, and other degenerative changes to take place. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me this informed consent document. I have discussed, or been given the opportunity to discuss, any questions concerning my treatment. My chiropractor explained and answered any questions/concerns to my satisfaction prior to my signing this informed consent document. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____

Printed Name Signature Date

PAYMENT INSURANCE INFORMATION

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Payment/Insurance Information

Our office policy states that payment is due when Services are rendered!

As a courtesy, we will file your auto and medicare insurance claims for you.

We are no longer in network with any health insurance. We can print you a receipt with the appropriate information for you to submit to your insurance company for possible reinbursement.

( ) Cash/check/credit card: payment is due when services are rendered.

( ) Automobile insurance: we must have a copy of your insurance card, verification of insurance and a copy of the accident report if available. Any charges not covered by the insurance company will be directly billed to you for payment.

( ) Medicare: we must have a copy of your medicare card.

Insured name:

Insured D.O.B.:

Relationship to insured:

Insurance company name:

I have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If balance owed after stated period has not been met, i understand that i will be responsible for all fees incurred (attorney, collection agencies, court cost, interest and any other fees needed to collect the balance) such that the balance owed to this office is paid in full.

Please print name: Date:

Please sign to acknowledge form: _____

RECEIPT OF PRIVACY PRACTICES

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ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES (located in the waiting room).

I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES.

I understand this form will be placed in my patient chart and maintained for a period of six years.

DATE:

PATIENTS NAME (PLEASE PRINT)

_____

SIGNATURE

PLEASE LIST BELOW THE NAME AND RELATIONSHIP OF PEOPLE TO WHOM YOU AUTHORIZE RELEASE OF PHI.

THIS FORM WILL BE MAINTAINED IN THE PATIENT'S CHART FOR A PERIOD OF SIX YEARS.