Clermont Chiropractic Life Center
1705 East State Road 50 Clermont, Florida 34711 352-394-7577
NEW PATIENT APPLICATION

Last Name: _____ First Name: _____MI_____ Date_____

Nick Name: _____ Date of Birth: _____/_____/_____ SS#_____-_____-_____
(needed for insurance billing only)

Address: _____ Apt #_____

City: _____ State: _____ Zip: _____ Phone: _____-_____-_____

Age: _____Sex: _____ Height: _____Weight:_____ E-Mail Address: _____

Driver's License #:_____ Marital Status: Married Single Divorced Widowed

Occupation:_____ Employer:_____

Are you a year round resident of Central FL? Y or N if no, when and Where:_____

Insurance Co: _____ Insurance ID #_____
(please give insurance card and drivers license to front desk for copying)

Name of Policy Holder: _____ Policy Holder's Date of Birth _____/_____/_____

Emergency Contact

Last Name: _____ First Name: _____

Phone _____-_____-_____ Relationship to Patient: _____

Is this condition related to an auto accident? Y or N **Date of Accident**: _____

Have you had this condition before? _____ If yes, when? _____

What doctors have seen you for this condition? _____

What did they do? _____

When was your last visit to a chiropractor? _____ Did it help? _____

Are there any other injuries to your spine, minor or major, that your doctor should know about?

_____

_____

List any medications, vitamins, supplements, etc. (*prescription & non-prescription, how many, how often*):

_____

_____

YOUR GOALS (Please circle all of your interests)

Chiropractic Scoliosis Reduction Nutrition/Weight Loss Wellness

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Problem Area #1 (Please list ONLY your PRIMARY complaint)

The pain is located where?_____

The pain started when? _____ ( ) days ago ( ) weeks ago ( ) months ago ( ) years ago

What caused it? _____

On a scale of 1-10 rate your pain: no pain 1 2 3 4 5 6 7 8 9 10 severe pain

How would you describe the pain? ( ) dull, achy ( ) sharp, stabbing ( ) burning ( ) pins and needles

The pain is made BETTER by:_____

The pain is made WORSE by: _____

The pain is: (constant, comes and goes, worse at night, etc) _____

There is radiating pain, tingling, or numbness into my _____

Additional Area # 2 (Please list ONLY your SECONDARY complaint)

The pain is located where_____

The pain started when? _____ ( ) days ago ( ) weeks ago ( ) months ago ( ) years ago

What caused it? _____

On a scale of 1-10 rate your pain: no pain 1 2 3 4 5 6 7 8 9 10 severe pain

How would you describe the pain? ( ) dull, achy ( ) sharp, stabbing ( ) burning ( ) pins and needles

The pain is made BETTER by:_____

The pain is made WORSE by: _____

The pain is: (constant, comes and goes, worse at night, etc) _____

There is radiating pain, tingling, or numbness into my _____

Additional Area # 3 (Please list ONLY your THIRD complaint)

The pain is located where?_____

The pain started when? _____ ( ) days ago ( ) weeks ago ( ) months ago ( ) years ago

What caused it? _____

On a scale of 1-10 rate your pain: no pain 1 2 3 4 5 6 7 8 9 10 severe pain

How would you describe the pain? ( ) dull, achy ( ) sharp, stabbing ( ) burning ( ) pins and needles

The pain is made BETTER by:_____

The pain is made WORSE by: _____

The pain is: (constant, comes and goes, worse at night, etc) _____

There is radiating pain, tingling, or numbness into my _____

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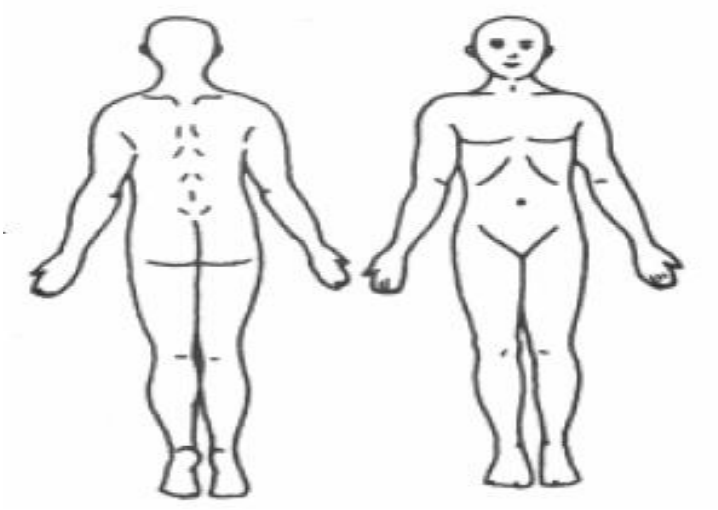
Other Concerns:

_____

_____

_____

PLEASE MARK the areas on the diagram with the following
Letters to describe symptoms **R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness



SOCIAL HISTORY

1. Smoking: ☐Cigars ☐Pipe ☐Cigarettes _____ ☐Daily☐Weekends ☐Occasionally☐Never
2. Alcoholic Beverages: _____ ☐Daily☐Weekends ☐Occasionally☐Never
3. Recreational Drug Use: _____ ☐Daily☐Weekends ☐Occasionally☐Never
4. Hobbies – Recreational Activities – Exercise Routine: How doe your present problem affect the following?

IDENTIFY TYPE: (golfing, swimming, running) Effect:

_____ ☐No Effect ☐Painful (can do) ☐Painful (Limits) ☐Unable to perform
_____ ☐No Effect ☐Painful (can do) ☐Painful (Limits) ☐Unable to perform

FAMILY HISTORY

Does anyone in your family suffer with the same condition? ☐Yes ☐No Who: _____
Any other hereditary conditions the doctor should be aware of? ☐Yes ☐No _____
Mother's History: ☐High Blood pressure ☐Diabetes ☐Cancer ☐Heart Disorders ☐Other _____
Father's History: ☐High Blood pressure ☐Diabetes ☐Cancer ☐Heart Disorders ☐Other _____

WORK ACTIVITIES

1. Hours worked per day: _____ Days per week: _____ Does your job require lifting? ☐Yes ☐No
   If yes, what is the maximum required? ☐Min (<5lbs) ☐Light (5-20lbs) ☐Med (20-50lbs)☐Heavy (>50lbs)
   Lifting frequency: ☐Constant (66-100% of Day) ☐Frequent (33-65 % of Day) ☐Occasional (0-32% of day)
2. Repetitive Activities:
   Computer: ___ hrs/day Grasping: ___ Hrs/day Hand tools: ___ hrs/day Machinery: ___hrs/day
   Assembly: ___ hrs/day Phone: ___ Hrs/day Other: _____hrs/day
3. Impact of current condition on work capacity: ☐No effect ☐Painful ☐Limits ☐Unable to work

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PERSONAL HISTORY

___ Fractured Bones
___ Auto Accidents
___ 0-1 year ago
___ 2-3 years ago
___ 4 years ago
___ Other Accidents/Falls
___ Back Curvatures
___ Arthritis
___ Diabetes
___ Swollen Painful Joints
___ Epilepsy
___ Skin Problems
___ Cancer
___Frequesnt Colds
___Depressed
___ Irritable
___ Anemia
___ Tremors
___ Allergies

___ Sinus problems
___ Eating disorders
___ Trouble sleeping
___Trouble concentrating
___ Learning Disability
___Mood Changes
___ Diarrhea/ Constipation
___ Pain/Stiff neck
___Tingling (Where_____)
___ Pain with cough/sneeze
___ Jaw Pain TMJ R or L
___ Shoulders tired
___ Difficulty Exercise
___ Hearing Loss
___ Lung Problems
___ Shoulder pain R or L
___ Dizziness
___ Ringing ears R or L
___ Asthma

___ Fainting
___ Loss of Balance
___ Blurred Vision
___ Double vision
___Upper back Pain
___Mid Back pain
___Headaches
___ Numbness Where___
___ Hemorrhoids
___Prostate Problems
___ Hip Pain L or R
___ Foot trouble
___ Chest Pain
___ Menopausal Problems
___ Pregnant
___ Difficulty Breathing
___ Heat problems
___ Stroke
___ High Blood pressure

___ Varicose veins
___ Liver trouble
___ Gall Bladder trouble
___ Digestive problems
___ Heartburn
___ Ulcers
___ Lower Back Pain
___ Colon Trouble
___ Change in weight
___ Fatigue
___ Impotence
___ Kidney Trouble
___ Menstrual Problems
___ Cold feet/ hands L R
___Reproductive
___Ear infections
___ AIDS/HIV
___Disc Problems

DAILY ACTIVITIES: Effects of Current conditions On Performance

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

FEMALES ONLY

1st day of your last menstrual cycle: _____ Are you Pregnant? ☐Yes ☐No Due Date: _____

Number of pregnancies: _____ Number of Children: _____ Type of birth: ☐ Natural ☐ Cesarean Section

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REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:
I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.
Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Clermont Chiropractic Life Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: X-rays/Imaging Studies
FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*
☐ The first day of my last menstrual cycle was on _____-_____-_____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Clermont Chiropractic Life Center (CCLC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. CCLC reserves the right to revise its Notice of Privacy Practices. I have the right to request that CCLC restrict how it uses or discloses my PHI to carry out TPO. With this consent, CCLC may call, mail or email me PHI in reference to matters that assist in carrying out TPO, such as appointment reminders, patient statements, and insurance items pertaining to my care. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or my insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CCLC may decline to provide treatment to me.
☐ I authorize and direct Clermont Chiropractic Life Center to **Release** copies of my medical records, x-rays, exam results and any other protected health information:

☐ I authorize and direct Clermont Chiropractic Life Center to **Request** copies of my medical records, x-rays, exam results and any other protected health information :

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. Any third party that receives protected health information is prohibited from further disclosing any information contained in the medical records without the consent of the patient or the patient's legal guardian.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I herby authorize the doctor to examine and treat my conditions he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be preformed. It is understood and agreed the amount paid the doctor for radiographs is for examination only and the radiographs will remain the property of the office. The patient also agrees the he/she is responsible for all bills incurred at the office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medically diagnosis.

Patient's Name: _____Signature:_____ Date: _____