Dania Beach Chiropractic Center

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CHART ID Number:	
DR: **JH TS**	Clinic**: DB NMB**
Dx1	Dx2
Dx3	Dx4

1 Confidential Patient Information

Patient's Full Name_____ Date:_____/_____/_____

Home Phone: _____ Cell Phone: _____

Mailing Address:_____Apt.#_____ City:_____ State:_____ Zip:_____

E-Mail: _____ □ Male □ Female Age:_____

Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Spouse's Name:_____ Employer:_____ Business Phone_____

Emergency Contact:_____Relationship:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Concurrent Health Care

Are you currently receiving treatment for this problem? Yes / No

Family Physician: _____ City: _____ State:_____ Phone_____

Have you had previous chiropractic care: □ Yes □ No If Yes, for what Problem: _____

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

2 Insurance Information:

Do you have health insurance? □ Yes □ No Company Name_____

Is Today's Visit Due To a: Work Related Injury □ Yes □ No **Auto Accident:** □ Yes □ No **Date Of Injury:_____**

(If yes to either questions above, please check with receptionist, additional information is needed)

Person Responsible for Account: _____ Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

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AUTHORIZATION AND ASSIGNMENT: In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated; you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it is all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Florida
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed DBCC are paid in full.

Patient Signature_____ Date_____

Initials:_____

Please complete this brief health questionnaire. If you need assistance, please ask. Your answers will help us determine how chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

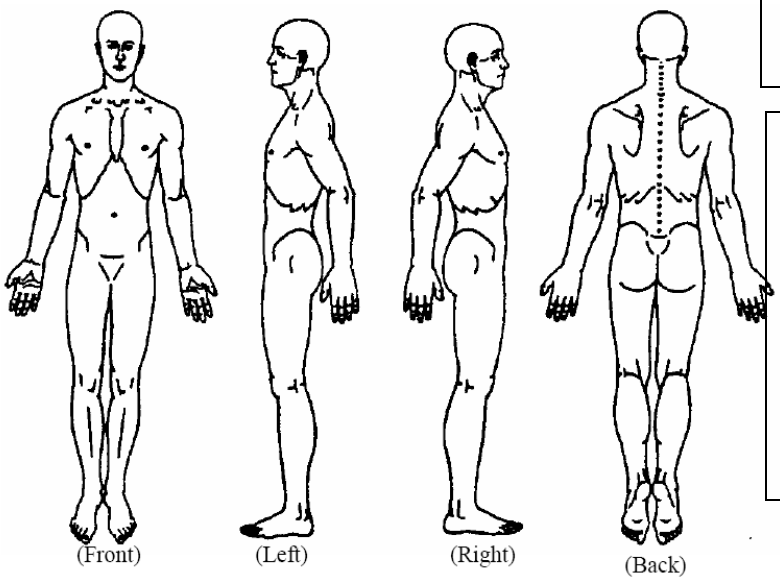
Chief complaint_____

Secondary or related complaint if any:_____ _____

Date of Onset: _____ Was the Onset: □ Gradual □ Sudden Since onset, has it gotten: □ Worse □ Better

Describe what caused the pain:_____ _____

PLEASE ANSWER THE FOLLOWING QUESTIONS
TO HELP EXPLAIN THE PROBLEM:



Please Mark Areas of Pain using these Codes
+++ Burning ### Dull/Ache * Numbness/Tingling**
=== Throbbing 000 Stabbing/Sharp

SEVERITY OF PAIN:
List region of pain and circle the number which represents the intensity of your pain.

1. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

2. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

3. Complaint:_____ 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

YOUR **CHIEF COMPLAINT:**

Describe the quality of the complaint/pain:
- □ sharp
- □ dull/ache
- □ throbbing
- □ tingling/numbness
- □ other:_____

Does any of the following make the pain worse:
- □ lifting □ bending □ pushing □ pulling
- □ cough □ sneeze □ bowel movement
- □ driving □ riding □ sitting
- □ walking □ running □ standing
- □ other:_____

Describe if pain is in a single spot or does is spread out:
- □ radiating dull □ deep ache
- □ pin point
- □ burning □sharp □stabbing, □tingling, □numb
- □ other:_____

Does any of the following make it better:
- □ rest □ laying down
- □ sitting
- □ walking □ exercise
- □ other:_____

How often are you aware of the pain:
- □ intermittent (less than 25% of time when awake)
- □ occasional (25-50% of time when awake)
- □ frequent (50-75% of time when awake)
- □ constant (75-100% of time when awake)

Does it interfere with your daily activities:
- □ minimal (annoyance, no impairment)
- □ slight (tolerated, some impairment)
- □ moderate (marked impairment)
- □ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following?
□ Muscle Weakness □ Bowel/Bladder problems □ Digestion □ Cardiac/Respiratory □ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): □ Yes □ No
If yes, explain;_____Results:_____

Past Health, Social and Family Health History:

Initials:_____

1. Have you ever experienced your present problem before for which you are consulting us: □ Yes □ No If yes, When:_____

2. Was treatment provided: □ Yes □ No If yes, By whom:_____ Outcome:_____

3. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, or surgeries?** If Yes please list them:

Date	Injury / Fracture / Illness	Treatment	Results

4. Is there any history of significant health problems in your family?

Relative	Age if Living	State of Health	Illnesses
Father			
Mother			
Sibling 1			
Sibling 2			

5. Current Weight_____lbs Have you recently lost or gained weight? □ Yes □ No Approximate Height_____

6. Do you regularly exercise? □ Yes □ No If yes, how many hours a week and what activities _____

7. Do you smoke? □ Yes □ No If yes, how many pack/day? _____

8. Do you drink alcohol? □ None □ light □moderate □ heavy How many glasses per week? _____

9. Check any conditions you have had:

□ AIDS/HIV
□ Allergies
□ Anxiety/Depression
□ Arm/shoulder pain
□ Arthritis
□ Asthma
□ Bladder Problems
□ Cancer
□ Chronic Fatigue
□ Deafness
□ Diabetes
□ Digestion Problems
□ Earache
□ Ear ringing
□ Epilepsy
□ Headaches
□ Headache – Migraine
□ Heart Disease
□ Herniated Disc
□ High blood pressure
□ Insomnia
□ Irregular Cycle
□ Kidney Problems
□ Leg Pain
□ Low back pain
□ Neck Pain
□ Osteoporosis
□ Poor Circulation
□ Prostrate Problems
□ Rheumatoid Arthritis
□ Sciatica
□ Shingles
□ Sinus Infections
□ Stroke
□ Thyroid Problems
□ TMJ
□ Venereal disease
□ Vertigo/Dizziness
Other:_____

Thank you for filling out the above information

OFFICE USE ONLY:

6 Please read and Sign the below form before examination and treatment

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me Regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness Date_____