Spinal Injury Centers
Dr. Joseph N. Salameh
1700 Wells Rd. Ste 15
Orange Park, Fl. 32073
O. 904.644.7034
F. 904.644.7471

Florida Patient's Bill of Rights Acknowledgment

As a new patient at our Health Care Facility, we would like to take this opportunity to advise you of your rights and responsibilities in accordance with Florida Statute 381.026 (6) which requires that we adopt and make available to all patients, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL

OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

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ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I acknowledge that **Spinal Injury Centers** provided a copy of the Notice of Privacy Practices and that I have read them (or decline the opportunity to read them) and understand the Notice of Privacy Practices.

FLORIDA PATIENT'S BILL OF RIGHTS

I acknowledge that **Spinal Injury Centers** provided a copy of the Florida Patient's Bill of Rights and that I have read them (or decline the opportunity to read them) and understand the Florida Patient's Bill of Rights.

I understand that this acknowledgement of receipt form will be placed in my patient chart and maintained.

_____ _____

Print Patient Name Date

_____

Signature of Patient (Guardian or Patient's legal representative)

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HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Worker's Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (*full Notice is available upon request)*

Changes to this Notice:
We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date on the first page.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of Receipt of this Notice:
We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records. This acknowledgment provides that you have declined to accept the Compete Notice and instead requested this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our facility, on our web site at address: www.spinalinjurycenters.com, and you may also ask for a copy.
Effective date: December 20, 2005

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Letter of Protection

PATIENT NAME: _____

ACCIDENT DATE: _____

INITIAL VISIT DATE (TODAY'S DATE): _____

I, the above named Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration: In consideration of the medical treatment provided and the medical provider's willingness to wait until the conclusion of my legal case and finalization of applicable insurance obligations to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action related to the above accident date.

Protection of Outstanding Charges: In the event that a financial recovery is made on my behalf by any person, attorney or other business entity in connection with any legal action related to the above accident date, I direct and instruct my present, and any future attorney representing me in connect with said legal action(s), to withhold from said recovery, funds sufficient to pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment provided in connection with same. I understand that in accordance with the Medical Provider's Financial Responsibility Policy, my Medical Provider has agreed to work with my Attorney and, as part of my settlement, or verdict, may in accordance with §817.234 (7) Florida Statues, accept a reduced amount or waive my outstanding balance altogether. I hereby irrevocably instruct my present and/or future attorney not to disburse any settlement funds for any reason, including but not limited to attorney's fees, costs, and other medical liens, until my Medical Provider has been contacted and my financial responsibility obligations are resolved.

Patient Responsibility: I understand that it is my responsibility to advise each and every attorney representing me of the existence of this agreement. I further direct my present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds that are recovered in connection with my case. I understand that under certain circumstances, I may not obtain any financial recovery and if that is the case, I am responsible for the payment of the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient.

Insurance: As discussed in the Financial Responsibility Disclosure, the Medical Provider will first attempt to collect payment for the medical treatment provided from any applicable automobile insurance company in accordance with the Florida No-Fault Law. Once the Insurance Company's financial responsibility is established, the Medical Provider will contact my attorney only in the event that an outstanding balance remains.

Payment: All payments made pursuant to this agreement shall be made to:

Enforcement: I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Approval Required: This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient.

The parties agree that no party shall be considered the drafting party to this contract.

Patient's Signature: _____ Date: _____

Medical Provider
Representative's Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS AND AUTHORIZATION

For good and valuable consideration, including the agreement of **JNS Physicians Group, LLC d/b/a *Spinal Injury Centers*** to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning **JNS Physicians Group, LLC** the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by **JNS Physicians Group, LLC,** for a motor vehicle accident that occurred on or about _____.
(Date of Injury)

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by **JNS Physicians Group, LLC d/b/a *Spinal Injury Centers***, is hereby directed to issue payment for those benefits directly to and payable to **JNS Physicians Group, LLC.**

I also authorize and assign to **JNS Physicians Group, LLC** the right to file suit and pursue all legal remedies to obtain payment for services provided to me by **JNS Physicians Group, LLC.** This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by **JNS Physicians Group, LLC** and includes the assignment to pursue declaratory relief or any other legal remedies.

JNS Physicians Group, LLC accepts the aforesaid assignment and hereby notifies any insurer issuing payment that **JNS Physicians Group, LLC** objects to any "re pricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

_____
Print Patient's Name

_____ _____
Patient's Signature (or guardians signature) **Date**

_____ _____
Witness to patient or guardian's signature **Date**

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AUTHORIZATION TO RELEASE/REQUEST MEDICAL RECORDS & INSURANCE

To Fax Number: (_____)_____ **Today's Date:** _____

MEDICAL RECORDS REQUEST/ INSURANCE INFORMATION RELEASE
(Office Use ONLY)

TO: _____ **ATTN:** _____
(Healthcare Provide/ Insurance Co.) (Person of Contact if known)

PATIENT: _____ _____ _____
(Patient's full printed Name) (Patient's Date of Birth) (Patient's SNN)

Date of Injury _____ **Claim #** _____

RELEASE OF PATIENT RECORDS AUTHORIZATION

I request the above listed health care provider to provide the following information: examinations, diagnostic test results, physical therapy records, and any other information that may be on file relative to my treatment.

I, _____ authorize the release of this information
(Print name)
to **Spinal Injury Centers.** I also authorize **Spinal Injury Centers** to release a copy of my patient records containing protected health information to other current providers involved in my health care. This authorization is given pursuant to ***Florida Statue 456.057*** and ***Federal HIPPA*** regulations. I understand that these regulations clearly state that any information disclosed to a third party is prohibited from further disclosing any medical information without the expressed consent of the patient or patient's legal representative.

I also authorize my insurance company to release information to JNS Physicians Group, LLC. d/b/a **Spinal Injury Centers.**

_____
Patient's or Patient's Legal Representative's Signature

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, Chiropractic doctors, Osteopaths, and Physical Therapist who 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 procedure may consist of manipulations/ adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with procedures as follows.

Soreness: I am aware, that like exercises, it is common to experience muscle soreness 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 disk, 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 one million, to once in ten million treatments. Once in one million is about the same chance as being struck by lightning, and once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Treatment results: I also understand that there are beneficial effects associated with treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will receive these benefits.

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 disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, or 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 have 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:_____ **Date:** _____

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INSURANCE & PAYMENT FOR CARE

Today's Date: _____
Date of Accident: _____

Auto Insurance Information

Name of Auto Insurance Company/ PIP _____

Policy #: _____ **Claim #:** _____

Adjusters Name_____ **Phone #** _____

Insurance Co. Address _____ **City** _____

State _____ **Zip code** _____ **Fax#**_____

Insured's Name: _____ **Relationship** _____

Insured's D/O/B: _____ **Insured's SSN:** _____

Insured's Address: _____ **Apt/Unit** _____

City _____ **State** _____ **Zip Code** _____ **Phone (___)_____**

Health Insurance Information

Name of Health Insurance Company _____

Group #: _____ **Policy ID:** _____

Insured's Name _____ **Relationship** _____

Insured's D/O/B: _____ **Insured's SSN:** _____

Deductible $_____ **has deductible been met? Yes _____ No _____**

Attorney Information

Attorney Name _____ **Phone (____)_____**

Case Manager _____ **Address** _____

City _____ **State** _____ **Zip Code** _____

Self Pay Information

We would like to take a moment to welcome you to **Spinal Injury Centers** and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, I would like to explain how your bills will be handled.

It is our policy in this office to maintain your account on a current basis. Charges for treatment are DUE AND PAYABLE at the time the service is provided. We accept cash, credit card (Visa, MC, Amex & Discover) or Apple Pay. We ask that you make payments on a PER VISIT BASIS. If you accrue a balance, it is also understood that you are responsible for any collection cost incurred. If you need to make alternate payment arrangements please let us know, often times we can reach an appropriate solution.

_____ _____

Patient Signature **Date**

***CANCELLATION POLICY: Please be kind enough to give us a 24-hour notice if you must change or cancel your appointment. Our office policy requires a $30.00 fee if adequate notice is not given. (Legitimate emergencies accepted)**

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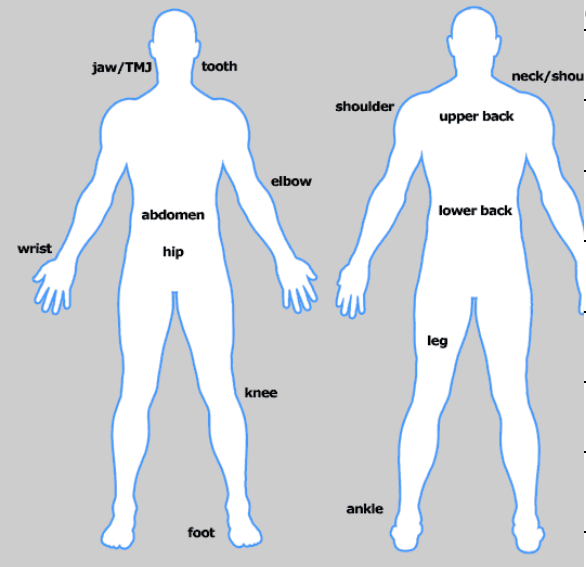
PATIENT INFORMATION FORM

	TODAY'S DATE:		DATE OF BIRTH:		
NAME:	☐ MALE ☐FEMALE	AGE:	☐MARRIED ☐DIVORCED	☐SINGLE ☐SEPARATED	☐WIDOWED ☐_____
ADDRESS:	CITY:		STATE:		ZIP:
HOME PHONE:	CELL:		FAX:		
SOCIAL SECURITY #:	DRIVER'S LICENSE:	STATE:	EMAIL ADDRESS:		
SPOUSE'S NAME:	AGES OF CHILDREN:		OCCUPATION/JOB TITLE:		
EMPLOYER/BUSINESS NAME:	BUSINESS ADDRESS:				
BUSINESS PHONE:	TYPE OF WORK:				
HOW DID YOU HEAR ABOUT US?					
EMERGENCY CONTACT:			PHONE #:		

INSURANCE				
	ADDRESS:		RELATIONSHIP:	
	WHO IS RESPONSIBLE FOR YOUR BILL?	☐SELF ☐WORKER'S COMP	☐AUTO INSURANCE MEDICARE	☐MEDICAID ☐OTHER (BE SPECIFIC):
	PERSONAL HEALTH INSURANCE CARRIER:		HEALTH ID CARD #:	
	INSURED PERSON'S NAME:		PRIMARY CARE PHYSICIAN:	
	INSURED PERSON'S SOCIAL SECURITY #:		PHARMACY:	

CURRENT HEALTH CONDITION



PLEASE CIRCLE AREAS OF DISCOMFORT

CHIEF COMPLAINT: (WHY ARE YOU HERE TODAY?)

BODY AREA INVOLVED:	☐CERVICAL (NECK)	☐UPPER EXTREMITY (ARMS, WRIST, HANDS)
	☐SPINE (MID-BACK), RIBS, PELVIS (LOW BACK)	☐LOWER EXTREMITY (LEGS, FEET, TOES)

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CONDITION:	☐NEW ☐RECURRING			☐EXACERBATION ☐CHRONIC		
MECHANISM OF ONSET:	☐AUTO ☐WORK	☐FALL ☐LIFTING	☐OVER EXERTION ☐REPETITIVE MOTION	☐UNKNOWN ☐SLEPT WRONG	☐SLIP OR FALL ☐NO INJURY	☐OTHER
SYMPTOMS:	☐PAIN ☐NUMBNESS	☐STIFFNESS ☐WEAKNESS				
LOCATION:	☐LEFT ☐RIGHT	☐BILATERAL				
QUALITY:	☐BURNING ☐DIFFUSE	☐DULL/ACHING ☐LOCALIZED	☐SHARP ☐SHOOTING	☐STABBING ☐THROBBING	☐TIGHTNESS ☐TINGLING	☐RADIATING ☐OTHER

ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS (RESTING):	0	1	2	3	4	5	6	7	8	9	10
ON A SCALE OF 0-10, (10 BEING THE WORST) RATE YOUR SYMPTOMS (WITH ACTIVITY):	0	1	2	3	4	5	6	7	8	9	10

DURATION: SYMPTOM(S) STARTED:								
SYMPTOM(S) WORSENED:								
SYMPTOM(S) LAST OCCURRED:								
SYMPTOM(S) LAST EPISODE:								
INJURY OCCURRED:								
ACCIDENT OCCURRED:								
TIMING WORSE IN THE:	☐MORNING	☐AFTERNOON	☐NIGHT	☐W/ACTIVITY	☐CONSTANT	☐INTERMITTENT		
ASSOCIATED SIGNS & SYMPTOMS:	☐BLURRED VISION ☐DEPRESSION ☐DIZZINESS	☐HEADACHES ☐IRRITABILITY/MOOD SWING ☐LOCALIZED TINGLING	☐NAUSEA ☐RADIATING ☐RINGING IN EARS	☐SLEEP DISTURBANCE ☐STIFFNESS				
QUALITY OF HEADACHES:	☐ DULL ☐ SHARP	☐THROBBING ☐STABBING	☐AURA ☐NO AURA	☐RADIATION: ☐WEAKNESS:	☐LEFT ☐LEFT	☐RIGHT ☐RIGHT	☐BILATERAL ☐BILATERAL	
OTHER ASSOC. SIGNS & SYMPTOMS:	☐ACHES ☐COLD LIMB ☐DIZZINESS ☐FATIGUE	☐FEVER ☐HEARTBURN ☐MUSCLE SPASM ☐NAUSEA	☐NUMBNESS ☐PALE BLUISH SKIN ☐PANIC ☐PINS & NEEDLES	☐RUNNY NOSE ☐STIFFNESS ☐SWEATING ☐SWELLING	☐TINGLING ☐VOMITING ☐WEAKNESS			
MODIFYING FACTORS – SYMPTOMS BETTER WITH:	☐ACTIVITY ☐BENDING	☐COLD ☐HEAT	☐MASSAGE ☒MOVEMENT	☐OTC MEDS ☐RX MEDS	☐REST ☐STRETCHING	☐SITTING ☐STANDING	☐TWISTING ☐WALKING	☐NOTHING HELPS
SINCE CONDITION BEGAN, HAS ANYTHING PERMANENTLY HELPED YOU?	☐YES ☐NO							

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HAS ANYTHING THAT YOU HAVE DONE, THUS FAR, FIXED YOUR PROBLEM	☐YES ☐NO

EMPLOYMENT

OCCUPATION:	WORK (HRS/DAY):

JOB CLASSIFICATION:	☐SITTING	☐LIGHT	☐MODERATE	☐HEAVY LIFTING	LIFTING FREQUENCY:	☐CONSTANT (66-100% DAY)	☐FREQUENT (33-65% DAY)	☐OCCASIONAL (0-32% DAY)

WORK ACTIVITY POSTURES: (HRS/DAY)	☐SITTING ☐STANDING	☐WALKING ☐CLIMBING	☐PUSHING ☐PULLING	☐KNEELING ☐REACHING	☐TWISTING ☐BENDING
REPETITIVE ACTIVITIES: (HRS/DAY)	☐COMPUTER ☐PHONE	☐MACHINERY ☐HAND TOOLS	☐ASSEMBLY ☐GRASPING		
HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE:	☐MILD PAINFUL (CAN DO) ☐MODERATE PAINFUL (LIMITED)	☐SEVERE (UNABLE TO PERFORM) ☐OTHER (EXPLAIN)			

DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITIES

ACTIVITY (CHECK APPLICABLE COLUMN)	0 NO EFFECT	1	2	3	4	5	6	7	8	9	10 UNABLE TO DO
BENDING:											
CARE –INFIRM FAMILY:											
CARRYING GROCERIES:											
CHANGE POS.–SIT-STAND:											
CLIMB STAIRS:											
DRIVING:											
EXTENDED COMPUTER USE:											
FEEDING:											
HOUSEHOLD CHORES:											
KNEELING:											
LIFT CHILDREN:											
LIFTING:											
PET CARE:											
READING (CONCENTRATION):											
SELF CARE:											
SELF CARE–BATHING:											
SELF CARE–DRESSING:											
SELF CARE–SHAVING:											
SEXUAL ACTIVITIES:											
SLEEP:											
STATIC SITTING:											
STATIC STANDING:											
WALKING:											
YARD WORK:											

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BELOW IS A LIST OF DISEASES THAT MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE. REVIEW OF SYMPTOMS – PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF "DENY"

CONSTITUTIONAL: ☐I DENY ANY CONST. ISSUE(S)	☐CHILLS ☐NIGHT SWEATS	☐WEIGHT GAIN ☐WEIGHT LOSS	☐FATIGUE ☐FEVER	☐DAYTIME SOMNOLENCE (DROWSINESS)			
EYE/VISION: ☐I DENY ANY EYE/VISION ISSUE(S)	☐BLINDNESS ☐DOUBLE VISION	☐EYE PAIN ☐PHOTOPHOBIA	☐TEARING ☐BLURRED VISION	☐FIELD CUTS (VISUAL FIELD DEFECT)	☐CATARACTS ☐GLAUCOMA	☐CHANGE IN VISION ☐ITCHING (AROUND EYES)	☐WEAR GLASSES AND/OR ☐CONTACT LENSES
EARS, NOSE, & THROAT: ☐I DENY ANY E/N/T ISSUE(S)	☐BLEEDING ☐DISCHARGE ☐DIZZINESS ☐SNORING	☐FAINTING ☐HEADACHES ☐LOSS OF SMELL ☐SORE THROATS (FREQUENT)	☐NASAL CONGESTION ☐SINUS INFECTIONS ☐DENTAL IMPLANTS	☐EAR DRAINAGE ☐EAR INFECTION(S) ☐HEARING LOSS ☐TINNITUS (RIGHT IN EARS)	☐POST NASAL DRIP ☐DIFFICULTY SWALLOWING ☐EAR PAIN	☐HOARSENESS ☐RHINORRHEA (RUNNY NOSE) ☐SINUS INFECTIONS ☐TMJ PROBLEMS	
RESPIRATION: ☐I DENY ANY RESPIRATORY ISSUE(S)	☐ASTHMA	☐COUGHING UP BLOOD	☐SPUTUM PRODUCTION	☐COUGH	☐SHORTNESS OF BREATH	☐WHEEZING	
CARDIOVASCULAR: ☐I DENY ANY CARDIO. ISSUE(S)	☐ANGINA (CHEST PAIN OR DISCOMFORT) ☐CHEST PAIN ☐CLAUDICATION (LEG PAIN OR ACHINESS)	☐HEART MURMUR ☐HEART PROBLEMS ☐ORTHOPNEA (DIFFICULTY BREATHING WHILE LYING DOWN)	☐PALPITATIONS (IRREGULAR OR FORCEFUL BREATHING OF THE HEART) ☐PAROXYSMAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH)	☐SWELLING OF LEGS ☐ULCERS ☐VARICOSE VEINS			
GASTROINTESTINAL: ☐I DENY ANY GI ISSUE(S)	☐ABDOMINAL PAIN ☐BELCHING ☐BLACK, TARRY STOOLS ☐CONSTIPATION	☐DIARRHEA ☐DIFFICULTY SWALLOWING ☐HEARTBURN ☐HEMORRHOIDS	☐INDIGESTION ☐JAUNDICE (YELLOWING OF SKIN) ☐NAUSEA ☐RECTAL BLEEDING	☐ABNORMAL STOOL CALIBER (QUALITY) ☐ABNORMAL STOOL COLOR ☐ABNORMAL STOOL CONSISTENCY		☐VOMITING BLOOD ☐VOMITING	
FEMALE: ☐I DENY ANY FEMALE ISSUE(S)	☐BIRTH CONTROL THERAPY ☐BREAST LUMP/PAIN ☐BURNING URINATION	☐CRAMPS ☐FREQUENT URINATION ☐HORMONE THERAPY	☐IRREGULAR MENSTRUATION ☐URINE RETENTION ☐VAGINAL BLEEDING	☐VAGINAL DISCHARGE			
MALE: ☐I DENY ANY MALE ISSUE(S)	☐BURNING URINATION ☐PROSTATE PROBLEMS	☐ERECTILE DYSFUNCTION	☐FREQUENT URINATION ☐URINATION RETENTION	☐HESITANCY/DRIBBLING			
ENDOCRINE: ☐I DENY ANY ENDOCRINE ISSUE(S)	☐COLD INTOLERANCE ☐DIABETES	☐EXCESSIVE APPETITE ☐EXCESSIVE HUNGER	☐EXCESSIVE THIRST ☐FREQUENT URINATION	☐GOITER ☐HAIR LOSS	☐HEAT INTOLERANCE ☐UNUSUAL HAIR GROWTH	☐VOICE CHANGES	
SKIN: ☐I DENY ANY SKIN ISSUE(S)	☐CHANGES IN NAIL TEXTURE ☐CHANGES IN SKIN COLOR	☐HAIR GROWTH ☐HAIR LOSS	☐HIVES ☐ITCHING	☐PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING)	☐RASH ☐HISTORY OF SKIN DISORDERS	☐SKIN LESIONS /ULCERS ☐VARICOSITIES	
NERVOUS SYSTEMS: ☐I DENY ANY NS ISSUE(S)	☐DIZZINESS ☐FACIAL WEAKNESS	☐HEADACHES ☐LIMB WEAKNESS	☐LOSS OF CONSCIOUSNESS ☐LOSS OF MEMORY	☐NUMBNESS ☐SEIZURES	☐SLEEP DISTURBANCE ☐STRESS	☐STROKES ☐TREMORS	☐UNSTEADINESS OF GAIT

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PSYCHOLOGICAL: ☐I DENY ANY PSYCHOLOGICAL ISSUE(S)	☐ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE)	☐ANXIETY ☐APPETITE CHANGES	☐BEHAVIORAL CHANGE(S) ☐BIPOLAR DISORDER	☐CONFUSION ☐CONVULSIONS	☐DEPRESSION ☐INSOMNIA	☐MEMORY LOSS ☐MOOD CHANGES
ALLERGY: ☐I DENY ANY ALLERGY ISSUE(S)	☐ANAPHYLAXIS (HISTORY OF SNEEZING)	☐FOOD INTOLERANCE	☐ITCHING ☐NASAL CONGESTION	☐SNEEZING		
HEMATOLOGY: ☐I DENY ANY HEMATOLOGY ISSUE(S)	☐ANEMIA ☐BLEEDING	☐BLOOD CLOTTING ☐BLOOD TRANSFUSION(S)	☐BRUISES EASILY ☐FATIGUE	☐LYMPH NODE SWELLING		

PAST HEALTH HISTORY – PLEASE FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

CHILDHOOD ILLNESS: ☐I DENY ANY CHILDHOOD ILLNESS(ES)	☐ADD ☐ALLERGIES/HAYFEVER ☐ASTHMA ☐ATOPIC DERMATITIS (ECZEMA)	☐BED WETTING ☐CEREBRAL PALSY ☐CHICKEN POX ☐DEPRESSION	☐DIABETES ☐EAR INFECTIONS ☐FETAL DRUG ☐EXPOSURE	☐FOOD ALLERGIES ☐HEADACHES ☐HEPATITIS ☐HIV	☐MEASLES ☐MUMPS ☐RASH ☐SCOLIOSIS	☐SEIZURE DISORDER ☐SICKLE CELL ANEMIA ☐SPINA BIFIDA ☐OTHER (PLEASE DESCRIBE)
ADULT ILLNESS:☐I DENY ANY ADULT ILLNESS(ES)	☐ALZHEIMERS ☐ANEMIA ☐ARTHRITIS ☐ASTHMA ☐CANCER ☐CHICKEN BOX ☐CHRON'S/COLITIS ☐CRPS (RSD) ☐OTHER _____	☐CVA (STROKE) ☐CYSTIC KIDNEY DISEASE ☐DEPRESSION ☐DIABETES (INSULIN) ☐DIABETES (NON INSULIN) ☐EAR INFECTIONS (FREQUENT) ☐EMPHYSEMA ☐EYE PROBLEMS	☐FIBROMYALGIA ☐HEART DISEASE ☐HEPATITIS ☐HIV ☐HYPERTENSION ☐INFLUENZA PNEUMONIA ☐LIVER DISEASE ☐LUNG DISEASE	☐LUPUS ERYTHEMA (DISCOID) ☐LUPUS ERYTHEMA (SYSTEMIC) ☐MULTIPLE SCLEROSIS ☐PARKINSON'S DISEASE ☐PLEURISY ☐PNEUMONIA ☐PSYCHIATRIC PROBLEMS ☐SCOLIOSIS	☐SEIZURE DISORDER ☐SHINGLES ☐STD'S (UNSPECIFIED) ☐SUICIDE ATTEMPT(S) ☐THYROID PROBLEMS ☐VERTIGO ☐PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION	
SURGERIES:☐I DENY ANY SURGERY (IES)	☐ANGIOPLASTY ☐APPENDECTOMY ☐CAESAREAN SECTION ☐CARDIAC CATHETERIZATION ☐CARPAL TUNNEL REPAIR	☐CORONARY ARTERY BYPASS ☐COSMETIC ☐D & C ☐DENTAL SURGERY ☐GALL BLADDER	☐HEMORRHOIDECTOMY ☐HERNIA REPAIR ☐HYSTERECTOMY ☐JOINT RECONSTRUCTION ☐JOINT REPLACEMENT	☐LAMINECTOMY ☐MASTECTOMY ☐PACEMAKER INSERTION ☐ROTATOR CUFF ☐SPINAL FUSION	☐TONSILLECTOMY ☐OTHER	
OB/GYN:☐I DENY ANY OB/GYN ISSUES	☐I HAVE NEVER BEEN PREGNANT ☐I HAVE BEEN PREGNANT IN THE PAST ☐I AM CURRENTLY PREGNANT	**MENSTRUAL HISTORY:** AGE OF ONSET _____	☐MY MENSES IS REGULAR ☐MY MENSES IS IRREGULAR ☐I AM CURRENTLY IN MENOPAUSE	DATE OF LAST MENSES ___/___/___		
INJURIES:☐I DENY ANY INJURY (IES)	☐BACK INJURY ☐BROKEN BONES ☐SEVERE FALL	☐FRACTURE ☐DISABILITY ☐HEAD INJURY	☐INDUSTRIAL ACCIDENT ☐JOINT INJURY ☐SEVERE LACERATION	☐MOTOR VEHICLE ACCIDENT ☐MILD/MODERATE SOFT TISSUE INJURY ☐SEVERE SOFT TISSUE INJURY		
IMMUNIZATIONS: ☐I DENY ANY IMMUNIZATION(S)	☐DTAP (DIPTHERIA, TETANUS & PERTUSSIS)	☐FLU ☐HEPATITIS A ☐HEPATITIS	☐HEPATITIS C ☐INFLUENZA ☐IPV (POLIO)	☐MMR (MEASLES, MUMPS, & RUBELLA) ☐PNEUMOCOCCAL ☐PPD (MANTOUX TEST-	☐SMALL POX ☐TB ☐VARIVAX (CHICKEN POX)	☐WHOPPING COUGH (PERTUSSIS)

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	B		TB)			
NON-DRUG ALLERGIES: ☐I DENY ANY NON-DRUG ALLERGIES	☐ANIMALS	☐DAIRY	☐EGGS	☐FOOD COLORING	☐MOLD	☐POLLEN

PREVIOUS TREATMENT

PREVIOUS CHIROPRACTIC CARE?	☐YES IF YES, WHO? (NAME) ☐NO		
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?	☐YES IF YES, WHO? (NAME) ☐NO	LOCATION OF OFFICE:	TYPE OF TREATMENT:
WERE YOU SASTIFIED WITH THE RESULTS OF YOUR TREATMENT?	☐YES EXPLAIN: ☐NO		

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS?	☐YES IF YES, PLEASE MARK OR LIST (BE SPECIFIC) ☐NO	☐ALLERGY MEDICATION ☐ANTI-DEPRESSANTS	☐BLOOD PRESSURE MEDS. ☐INSULIN	☐MUSCLE RELAXERS ☐NERVE PILLS	☐PAIN KILLERS ☐OTHER (PLEASE SPECIFY)
DO YOU WEAR ANY OF THE FOLLOWING?	☐HEAL LIFTS ☐INNER SOLES	☐ARCH SUPPORTS ☐ORTHOTICS	PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT – EVEN IF UNRELATED		

FAMILY HISTORY – ENTER INITIALS BELOW: A = ALIVE D = DECEASED

___ GENERAL FAMILY ___ FATHER	___ MOTHER ___ PATERNAL GRANDFATHER	___ PATERNAL GRANDMOTHER ___ MATERNAL GRANDFATHER	___ MATERNAL GRANDMOTHER ___ SON(S)	___ DAUGHTER(S) ___ BROTHER(S)	___ SISTER(S)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

SOCIAL HISTORY

ALCOHOL:	☐NEVER ☐DAILY ☐WEEKLY ☐MONTHLY	☐SOCIAL CONSUMPTION ONLY	☐BEER ☐LIQOUR ☐WINE	OZ.'S # GLASSES	**DIET:** MARK ALL THAT APPLY	☐HIGH FAT ☐HIGH FIBER ☐HIGH PROTEIN ☐HIGH SALT	☐ LOW CALORIE ☐ LOW CARB ☐ LOW SUGAR	☐ LOW FIBER ☐ LOW SALT

DRUGS:	☐ DENY ANY ILLEGAL DRUG USE ☐ DENY USE OF IV DRUGS	☐ HAVE NOT USED DRUGS SINCE _____ ☐ HAVE USED DRUGS FOR _____	**TOBACCO:**	☐ DENY TOBACCO USE ☐ LIVE W/A SMOKER ☐ QUIT SMOKING	# PER: ___	☐ DAY ☐ WEEK ☐ MONTH ☐ # CHEW ____

PLEAE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that S will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to chiropractic clinic will be credited to my account upon 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 or treatment, any fees for professional services rendered me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE: (SIGNATURE INDICATES CONSENT TO TREAT)	**DATE:**

PATIENT (PRINT NAME):	**PATIENT'S SIGNATURE:**	**DATE:**