

Date: _____

PATIENT INFORMATION

Name _____ Sex M F Birthdate _____
last MI first

Address _____
street/ p.o. box city state zip

Marital Status Single Married Widowed Separated Divorced

Social Security # _____

Occupation _____

Primary Phone _____ Secondary Phone _____

EMERGENCY CONTACT

Name _____ Relationship _____
last MI first

Primary Phone _____ Secondary Phone _____

EMPLOYER INFORMATION

Employer _____

Address _____
street/ p.o. box city state zip

Phone _____

SPOUSE INFORMATION

Name _____

Birthdate _____ Social Security # _____

Occupation _____ Employer _____

Who may we thank for referring you? _____

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Mark an X on the picture where you experience pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). _____

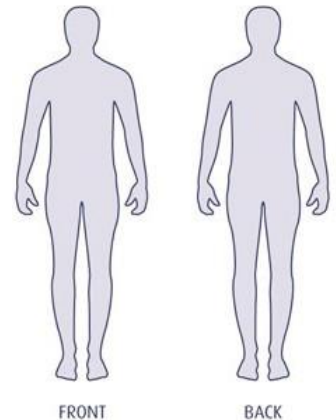
Type of pain (check all that apply) Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness
 Swelling Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with (check all that apply) Work Sleep Daily Routine Recreation

Activities or movements that area painful to perform (check all that apply) Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for this condition?

- Medications Surgery Physical Therapy Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|--|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors/Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Headaches | | |

CONDITION

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs per day _____
 Drinks per week _____
 Cups per day _____
 Reason _____

Are you pregnant? Yes No if so, Due date: _____

INJURIES/SURGERIES	description	date
Falls	_____	_____
Head injuries	_____	_____
Broken bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

 Pharmacy #: _____



PATIENT HEALTH INFORMATION CONSENT

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy or your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for 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 defects, 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, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating healthcare service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Orlando Spine and Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Orlando Spine and Wellness Center to use and/or disclose all medical records and bills to the entities below:

REQUESTOR'S NAME: _____

PATIENT'S NAME _____ D.O.A. _____

PATIENT ADDRESS _____

DATE OF BIRTH _____ SSN _____

This authorization shall expire upon this expiration date: _____.
If I fail to specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Orlando Spine and Wellness Center. I understand that the revocation will not apply to information that has already been released to this authorization. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may refuse to sign this authorization and it is strictly voluntary.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

A photocopy of this authorization is to be accepted and given the same effect as the original.

Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

Signature of Witness Date

ACCIDENT/INJURY REPORT FORM

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____

Weather condition at the time of Accident: clear raining foggy other

Were you the: driver front passenger rear passenger

Were you wearing a seatbelt? yes no Braced for impact? yes no

What direction was the impact from? front rear right side left side

Did you go to the hospital right away? yes no Later? yes no

If so, which hospital? _____

Were you x-rayed there? yes no

What treatment did you receive? medication other _____

Have you seen other doctors as a result of this accident? yes no

If yes, please list: _____

Have you had any previous permanent injuries as a result of prior accidents, injuries or illness? no yes

If yes, please describe when and what: _____

Part of the body injured

- | | | | |
|----------------------------------|-------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Abdomen | Ankle | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Back | Arm | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Chest | Ear | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Face | Elbow | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Fingers | Eye | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Head | Foot | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Mouth | Hand | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Nose | Knee | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Scalp | Leg | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Teeth | Wrist | <input type="checkbox"/> right | <input type="checkbox"/> left |

Other (specify) _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____ High Stress Activity

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Cancer									
Constipation									
Diabetes									
Disc Herniations									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
Insomnia									
High Blood Pressure									
Kidney Trouble									
Liver Trouble									
Migraine									
Neuritis									
Neuralgia									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____