PATIENT DATA: **DATE:**_____

Title: (Circle one) MR. MRS. MS. MISS DR. OTHER_____

FIRST NAME: _____ **LAST NAME:** _____

I go by _____

ADDRESS : _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: (_____)_____-_____ **CELL PHONE:** (_____) _____-_____

EMAIL: _____

DATE OF BIRTH: _____/_____/_____ **GENDER:** ____MALE ____FEMALE

MARITAL STATUS: ____SINGLE ____MARRIED ____ DIVORCED ____ WIDOWED ____OTHER

EMPLOYMENT STATUS: ____EMPLOYED ____UNEMPLOYED ____RETIRED ____OTHER

_____FT STUDENT _____PT STUDENT

OCCUPATION: _____

EMPLOYEER: _____
ADDRESS: _____
_____
PHONE #: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP : _____

CONTACT HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

PATIENT NAME _____ **DATE** _____

MEDICAL CONDITIONS: (Check all that apply to you)

_____	ARTHRITIS	_____	HYPERTENSION
_____	CANCER	_____	PSYCHIATRIC ILLNESS
_____	DIABETES	_____	SKIN DISORDER
_____	HEART DISEASE	_____	STROKE

OTHER _____

SURGERIES: (Check all that apply to you)

_____	APPENDECTOMY	_____	BRAIN		
_____	CARDIOVASCULAR PROCEDURE	_____	SHOULDER	_____ L	_____ R
_____	CERVICAL SPINE	_____	THORACIC SPINE		
_____	HYSTERECTOMY	_____	KNEE	_____ L	_____ R
_____	JOINT REPLACEMENT	_____	CARPAL TUNNEL	_____ L	_____ R
_____	PROSTATE	_____	GASTRO-INTESTINAL		
_____	LUMBAR SPINE	_____	URO-GENITAL		
_____	GALL BLADDER	_____	HERNIA		

OTHER _____

ALLERGIES: (List any allergies you have)

_____

_____

_____

SOCIAL HISTORY: (Check all that apply to you)

Caffeine use:	occasional _____	often _____	never _____
Drink Alcohol:	occasional _____	often _____	never _____
Exercise:	occasional _____	often _____	never _____
Tobacco Use:	occasional _____	often _____	never _____

Sleep: Hours per night _____

Stress Level: High____ Moderate _____ Low_____ None _____

FAMILY HISTORY: (Check all that apply)

	PARENT	**SIBLING**
Arthritis:	_____	_____
Cancer:	_____	_____
Diabetes:	_____	_____
Heart Disease:	_____	_____
Stroke:	_____	_____
Thyroid:	_____	_____

OTHER _____

REVIEW OF SYSTEMS: (Check only symptoms you've had trouble within the last 3 months)

GENERAL:
_____Weight Change
_____ Fever
_____ Chills
_____ Night Sweats
_____ Weakness
_____ Fatigue

Skin:
_____Rash
_____ Itching
_____ Hair Changes
_____ Nail Changes

Cardio:
_____ Murmur
_____ Chest Pain
_____ Palpitations
_____ Difficulty Breathing
_____ Wheezing
_____ Blue Extremities
_____ Swollen Extremities

Eyes:
_____ Vision
_____ Pain
_____ Discharge

Neurologic:
_____ Headache
_____ Dizziness
_____ Fainting
_____ Convulsions

Breasts:
_____ Mass
_____ Pain
_____ Discharge
_____ Self-Exam

Ears:
_____ Hearing
_____ Ringing
_____ Pain
_____ Discharge

G.I.:
_____ Appetite
_____ Abdominal Pain
_____ Vomiting
_____ Diarrhea
_____ Constipation

Psychologic:
_____ Anxiety
_____ Depression
_____ Moods
_____ Memory

Nose:
_____ Pain
_____ Bleeding
_____ Taste

G-U:
_____ Frequent Urination
_____ Painful Urination
_____ Incontinence

Musculoskeletal:
_____ Neck
_____ Upper Extremities
_____ Upper Back
_____ Lower Extremities
_____ Lower Back

Mouth / Throat:
_____ Sores
_____ Bleeding
_____ Taste

ADDITIONAL INFO:

Please list **ALL** current medications and/or supplements being taken:

_____
_____
_____
_____
_____

PATIENT NAME _____ **DATE** _____

Are you pregnant? _____ Yes _____ No _____ N/A

HEIGHT: ____**ft** ____**in** **WEIGHT:** _____**lbs**

By using the key below, indicate on the body diagram where you are experiencing pain:

X - ACHING

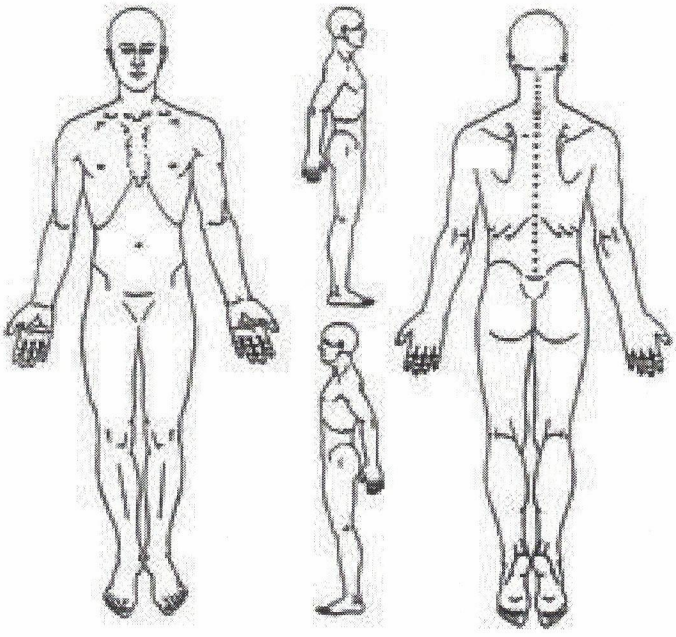
^ - BURNING

~ - SPASM

O - PINS & NEEDLES

\ - STABBING

< > - NUMBNESS



On an average rating from 0-10, how much pain are you experiencing: 0=no pain and 10= the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

(FOR OFFICE USE ONLY .....)

O
P
P
Q
R
S
T

_____
_____
_____
_____
_____
_____
_____

ACTIVITIES OF DAILY LIVING:

Please circle if you have pain or difficulty performing the following:

Bending	Carrying Groceries	Household Chores
Driving	Sitting to Standing	Kneeling
Extended Computer Use	Climbing Stairs	Reading (Concentration)
Lift Children	Lifting	Pet Care
Self Care - Bathing	Walking	Sexual Activities
Self Care - Dressing	Sleep	Yard Work
Prolonged Sitting	Prolonged Standing	Other_____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes_____ No_____ Date:____/____/____

Time: _____a.m. / p.m.

If work is responsible, please fill out the following:

Employer: _____
Your occupation: _____
Job description: _____
Address: _____
City:_____
State: _____ Zip Code: _____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

PRIMARY CARE PHYSICIAN: _____

PCP PHONE # (_____) _____-_____ ADDRESS: _____

WOULD YOU LIKE FOR US TO SEND OFFICE NOTES TO YOUR DOCTOR: _____YES _____NO

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and / or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name_____

Patient's Signature_____ Date_____

Consent to Treat a Minor: (Minor's Printed Name)_____

Guardian / Spouse's Signature Authorizing Care:

_____ Date_____

***** CANCELLATION POLICY*****

We are very pleased to participate in your healthcare, and have set aside time for your appointment.
We understand that sometimes it is necessary to cancel or change an appointment. In consideration of others who need care, we ask that if you are unable to keep your appointment with our office, please let us know as soon as you can, either by phone, email, or by replying to the text notification.

If you are unable to do this, you will be billed a $25 no-show fee.

_____please initial here to acknowledge reading policy. Thank you!

FLORIDA COAST
CHIROPRACTIC CLINIC

CONSENT FOR CHIROPRACTIC CARE

One treatment I use as a Dr of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

As a patient coming to Florida Coast Chiropractic Clinic, you give the doctor permission and authority to care for you, 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 deformities or pathologies may render the patient susceptible to injury. The doctor, or 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 whatever he/she is suffering from: defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides specialized non-duplicating healthcare service.

Your Chiropractic Physician is licensed in a special practice and is available to work with other types of providers in the healthcare regime.

"I understand if I am accepted as a patient by a physician at Florida Coast Chiropractic Clinic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon request."

Dated: _____

_____

(Please print patient name)

_____

(Patient signature)

_____

(Signature of Parent or Guardian)

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Florida Coast Chiropractic Clinic, Inc. on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Florida Coast Chiropractic Clinic, Inc. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Florida Coast Chiropractic Clinic, Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____

Print Name of Patient, Authorized Representative or Responsible Party