Kerinver
Chiropractic Care for a Healthier You.

Date: ____________________________

Last Name: ____________________________ First Name: _____________________ Mid Init: ______________________

Address: ______________________________ City: ________________________ Zip: __________________________

Home Phone: ______-________-___________ Cell # ______-_______-________ Other: ________________________

Birthday: _____________________________ Sex: ____ M ____ F Email: ________________________

Marital Status: ______ Married ______ Single ___ Divorced ___ Widowed

***If Patient Is A Minor:* Responsible Party's Name: ____

Attorney Name: _____________________________________ Phone # _________-_________-____________

Best time to contact you: ________ AM __________ PM _________ Evenings Time: ___________________

Employer: ____ Ph # ________________________________

Employers Address: ____ Occupation: __________________________

Auto Insurance: Date of Accident: ________________________
Insurance Name: _______________________________________
Address: ____
State: ___________________ Zip: _______________________
Policyholder Name: _____________________________________
Policyholder DOB: ______________________________________
Policy ID #: ____
Claim #: ____

Health Insurance:
Insurance Name: ______________________________
Address: _____________________________________
State: ___________________ Zip: ______________
Policyholder Name: ____________________________
Policyholder DOB: _____________________________
Policy ID #: __________________________________
SS #: ________________________ If used as ID#

Spouse's Name: ___________________________________ or Emergency Contact: ____________________________

Spouse's Birthdate: _________________________________ Relationship: ____________________________________

Employer: ______________________________ Phone #: ____________________ Cell #: ______________________

Please check all reasons you selected us for your care: Which is the primary reason? # ____________

1. Family Doctor (name) _________________________ 2. Previous Patient (name) ____________________
3. Referred by family/friend (name) _________________ 4. Reputation of Clinic: _______________________
5. Insurance Handbook _________ 6. Website _________________ 7. Other: ________________________

Chiropractic Clinic of Central Florida, LLC
1958 East Osceola Pkwy Kissimmee, Florida 34743 |
Phone: 407-483-3598 Fax: 407-483-3599

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Medical History Form

Name: ____ DOB: ______________ Date_________________

Medical Doctor Name____ Phone Number________________

Main Problem

What pain causes you to come to the office? ____
What caused this pain? ____
When did this pain start? _________________________________ How long does this pain last? ______________
How often does this pain occur, circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other areas? ____
What makes this pain better? ____
What makes this pain worse? ____
What else have you done to treat this pain? ____

Other Problem

What other pain do you have? ____
What caused this pain? ____
When did this pain start? __________________________________How long does this pain last? ______________
How often does this pain occur, circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other area? ____
What makes this pain better? ____
What makes this pain worse? ____
What else have you done to treat this pain? ____

Medical History

Allergies	Anemia	Arthritis	Asthma
Depression	Back Problems	Hearing Disorder	Cholesterol Disorder
Heart Murmur	Diabetes	Heart Disease	Kidney Disorder
HIV/Hepatitis	Hypertension	Lung Disease	Skin Problems
Prostate Disorder	Seizures	Skin Cancer	Vision Problems
Stroke	Stomach/Digestive Disorder		

Cancer (Specific Type): ____

Other: ____

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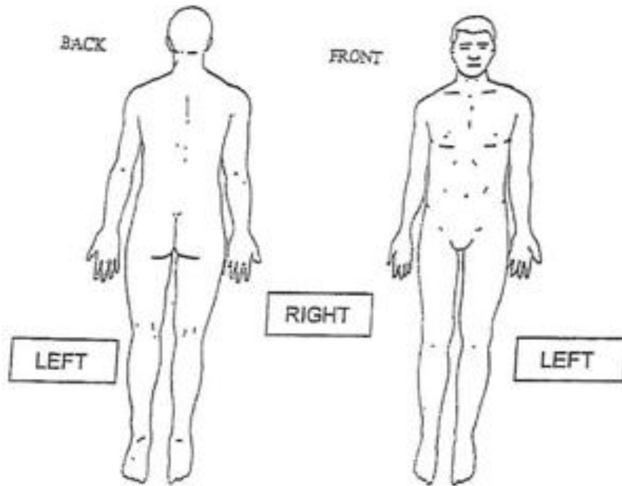
Patient Name ___________________________________ DOB: ___________ Date: ________________

Height: __________ Weight: __________ BP: _______/_______ Pulse: __________



Rate your overall pain, soreness or achiness. (circle one of the following)

No Pain is 0 **Severe Pain is 10**

1 2 3 4 5 6 7 8 9

On the picture, mark with an X the areas where you are experiencing pain or discomfort.

Additional Symptoms and Complaints:

____

____

____

Have you lost time from work due to your injury? Y N

If yes, please give dates: ____

Type of employment: ____

Have you had previous injuries or accidents? Y N

Description of previous injury and/or accident:

____

____

____

Is there any residual pain from the previous injury and/or accident? Y N

How much better did you feel prior to your current condition? (example 100%, 80% etc.)

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Name: ________________________________ DOB: __________ Date: ______________________

Please tell us the health of you parents, siblings and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living/Deceased	Heart	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease
Father	L D Cause:								
Mother	L D Cause:								
Sibling M Child F	L D Cause:								
Sibling M Child F	L D Cause:								

Past and Social History:

Are you employed **Y N** Where ______________________ How's your Health? ___________

Do you drink alcohol **Y N** Use tobacco **Y N** Use recreational drugs **Y N**

Have you had any illnesses in the past?

____

Have you been hospitalized?

____

____

Have you had any surgeries?

____

____

List any medications that you are on?

____

____

I certify the information that I have given here is true and accurate to the best of my knowledge.

Signed ____ Date___________________

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Patient Name: ___________________________ DOB: _____________

SYSTEM REVIEW

Circle the condition in each category that cause you problems or discomfort:

GENERAL
Recent weight change
Fever
Fatigue
Headache

INTERGUMENTARY(Skin/breast)
Rash or itching
Change in the hair or nails
Varicose veins
Breast pain
Breast lump
Breast discharge
History of breast cancer
Last mammogram ________
History of cyst

EYES
Eye disease or injury
Glasses/Contac lenses
Blurred/Double vision
Glaucoma

EARS/NOSE/THROAT/MOUTH
Hearing loss or ringing
Earache or drainage
Chronic sinus problems
Nose bleeds
Mouth sores
Bleeding gums
Bad breath or bad taste
Sore throat or voice change
Swollen glands in neck

RESPIRATORY
Chronic or frequent cough
Spitting up blood
Shortness of breath
Asthma or wheezing

CARDIOVASCULAR
Health trouble or murmur
Chest pain
Palpitation
Shortness of breath
Swelling of feet

GASTROINTESTINAL
Loss of appetite
Change of bowel movement
Nausea or vomiting
Frequent diarrhea
Constipation/painful bowel
Rectal bleeding/bloody stool
Abdominal pain or heartburn
Peptic ulcer

GENITOURINARY
Frequent urination
Burning/painful urination
Blood in urine
Forced/stained urination
Incontinence/dribbling
Kidney stone
Sexual difficulty
Painful menstruations
Vaginal discharge
Irregular menstruation
Last PAP smear _______________
Total pregnancies _____________
# of deliveries ________________
# of miscarriages ______________
Method of birth control_________
____

MUSCULOSKELETAL
Joint stiffness
Joint pain
Muscle weakness
Back pain
Cold extremities
Difficulty walking
Muscle pain/cramps

NEUROLOGICAL
Frequent headaches
History of concussion
Light headed/dizziness
Seizures
Numbness/tingling
Tremors
Paralysis
Stroke

ENDOCRINE
Glandular/hormone problem
Thyroid disease
Diabetic
Excessive thirst/urination
Heat or cold intolerance
Dry skin
Change in hat or glove size

HEMATOLOGICAL/LYMPHATIC
Slow to heal after cuts
Bleeding or bruising
Anemia
Phlebitis
Past transfusion
Enlarged glands
Hepatitis A B C /HIV

LIST YOUR ALLERGIES
____
____
____
____
____
____

LIST ALL MEDICATIONS
____
____
____
____
____
____
____
____
____
____

Patient initials: _______________

Date: ____________________

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AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH

I, _________________________________, hereby authorize Chiropractic Clinics of Central Florida to obtain, release, or review protected health information in accordance with deferral law and state law. This authorization will expire one (1) year from the date of my signature if I fail to specify a date, event, or condition of expiration.

Issued to: ____

Name of physician, individual, agent, or health care facility

For the purpose of: ( ) Medical Treatment ( ) Other: ______________________________

Dates of Services: From: ___________________________ To: _______________________________

I understand that this authorization is revocable upon written notice to the office where the original authorization was retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV, and/or AIDS information is confidentially protected by Federal and State Law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information. I understand that my medical records with protected health information will be released to insurance companies for billing purposes during the processing of claims. I further understand that Chiropractic Clinics of Central Florida may not condition the provision of treatment, payment, and enrollment in health plan or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be obtained, released, or review

____Complete medical record/Medical record abstract/All diagnostic test.
____Medical records and progress notes
____Imaging studies reports/ MRI reports/ CT reports/ VF reports/ Ultrasound reports

Other: ____

People authorized to obtain patient information:

Name: __________________________________ Relationship with the patient: ___________________________

Name: __________________________________ Relationship with the patient: ___________________________

Name: __________________________________ Relationship with the patient: ___________________________

Revoked Authorization of Denied Releases

____ I do not want my medical record released to the following persons, agencies, or individuals and revoke any prior authorization to such persons or entities.

____

Name and addresses of withheld release entities

Patient signature: ___________________________ DATE: _____________ DOB: ________________________

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

____________________	__________	______________________	______
Printed name of patient	DOB	Signature of Patient	Date
____________________	__________	______________________	______
Signature of Representative (If patient is a minor or is handicapped)	DOB	Witness to Patient's Signature	Date

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PATIENT CONSENT FORM

Federally Mandated Privacy Regulation Requirement

I hereby give my consent for Chiropractic Clinics of Central Florida or my physician(s) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Chiropractic Clinics of Central Florida or my physician(s) describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Chiropractic Clinics of Central Florida or my physician(s) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to (insert name and address of privacy officer for the practice).

With this consent, Chiropractic Clinics of Central Florida or my physician(s) may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Chiropractic Clinics of Central Florida or my physician(s) may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential”.

With this consent, Chiropractic Clinics of Central Florida or my physician(s) may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Chiropractic Clinics of Central Florida or my physician(s) restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Chiropractic Clinics of Central Florida or my physician(s) to use and disclose my PHI to carry out TPO.

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, Chiropractic Clinics of Central Florida or my physician(s) may decline to provide treatment to me.

Patient/guardian must be provided with a signed copy of this authorization form.

______________________	________	______________________	____________
Print Name	DOB	Patients Signature	Date

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Patient Agreement / Assignment of Benefits

(Please complete the form in full. Send copy of insurance card if available)

Patient Information

Patient Name ____

Date of Birth ___________ SS# _______________ Date of injury or Onset of Symptoms ___________________

Address ____________________________ City _______________ State __________ Zip __________________

Phone __________________ Alt Phone ___________________ Email __________________________________

Insurance Information

Insurance Type: Private PPO Workers Compensation Self Pay Auto Other: _____________________

Name of insured __________________________ Insurance Company _________________________________

Policy/Claim# ___________________________ Group # ____

Home Phone _____________________________ Mobile Phone _______________________________________

Assignment of Benefits/Release of information

Patient Signature Required for Proof of Delivery, Assignment of Benefits, Acknowledgement of Receipt of Privacy Notice, and Terms and Conditions of agreement.

By signing below, I authorize Chiropractic Clinics of Central Florida to submit a claim for such service(s) to my insurer on my behalf and assign the benefits payable by my insurer to CCCF. I authorize my Health Care Provider and CCCF to release any of my medical information required by my insurer to process the claim.

I understand that CCCF does not waive patient balances and that I am responsible for any and agree to pay any portion of the amount due for such service(s) not paid for by my insurer, whether resulting from deductible, co-pays, determination of non-coverage, or otherwise. In the event benefit payments due CCCF are paid directly to patient, the payee shall immediately endorse and remit to CCCF all such benefit checks. I understand that the CCCF Privacy Policy and the Patient Bill of Rights and Responsibilities **are available on the CCCF website (www.chiropractorkissimmee.com) and will be delivered to me with the device and I can contact customer service at 407-483-3598, if I have any questions.**

***Patient Signature ____ Date ______________________**

Guarantor/Legal Rep (If patient unable to sign) ____

Relationship to patient ____ Date _______________________

FAX TO CCCF: **(407) 483-3599**

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