CORAL REEF CHIROPRACTIC CENTER, PA

NAME (Last, First, Middle Initial)		HOME PHONE	TODAY'S DATE	
COMPLETE ADDRESS (Include City, State & Zip)		CELL PHONE	DATE OF BIRTH	
OCCUPATION	EMPLOYER NAME	EMAIL	AGE	SEX [ ]M [ ]F
[ ] MARRIED [ ] WIDOWED [ ] SINGLE [ ] DIVORCED	NAME OF SPOUSE	NAMES OF CHILDREN		

COMPLAINTS (Briefly describe each complaint by order of severity):

1	
2	
3	
4	
5	
6	
WHEN DID THE PROBLEM START?	HOW DID THE PROBLEM START?
REFERRED BY:	PREVIOUS CHIROPRACTIC CARE? [ ] NO [ ] YES – WHERE?
PLEASE INDICATE IF YOU ARE HERE BECAUSE OF AN INJURY: [ ] ON THE JOB [ ] AUTO ACCIDENT [ ] HOME INJURY	DATE:

HAVE YOU EVER HAD FALLS, AUTO ACCIDENTS OR INJURIES?

MO/YR	TYPE OF ACCIDENT	DESCRIBE INJURY

HAVE YOU EVER HAD SURGERY?

MO/YR	TYPE OF SURGEY	COMMENTS

ARE YOU PRESENTLY TAKING MEDICATIONS?

NAME:	DOSES/DAY:	LENGTH OF TIME TAKING:

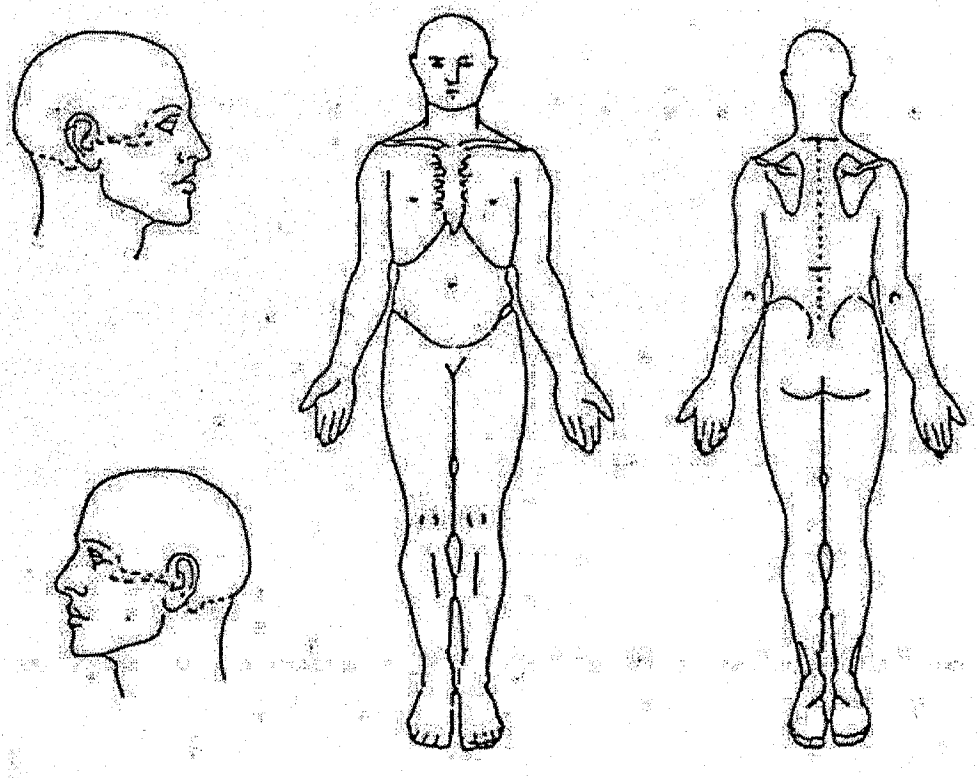
PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop over time

How would you describe your pain? ☐ No pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching
☐ Stabbing ☐ Other _____

How would you rate your pain on a scale from 0 to 10? (please circle)
(no pain) **0 1 2 3 4 5 6 7 8 9 10** *(worst pain possible)*

Has it: ☐ stayed the same ☐ become worse ☐ Improved

What makes your pain or problem feel worse? ☐ Walking ☐ Standing ☐ Daily activities ☐ Resting ☐ Running
☐ Other _____

What makes your pain or problem feel better? _____

What treatments have you had for this problem? _____

Social History
Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current Use - Type _____ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _____ ☐ Smoke ____ packs/day for ____ years

Employer: _____ Occupation: _____
How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
Do others depend upon you for their care? ☐ Spouse ☐ Children–age(s) _____
☐ Elderly or disabled family member ☐ Other _____

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily
Types of exercise: _____

Family History
Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Other _____

Your Medical History
Allergies: ☐ None Known ☐ Mediations: _____ ☐ Foods _____
☐ Others: _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____ _____
Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian Date

_____
Doctor Signature

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that CORAL REEF CHIROPRACTIC CENTER has a privacy policy which fully explains my privacy rights as it pertains to care provided at this facility. I may, at any time, request a copy of this policy.

I hereby give my consent for CORAL REEF CHIROPRACTIC CENTER to use and disclose protected health information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). CORAL REEF CHIROPRACTIC CENTER's Notice of Privacy Practices provides a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing consent. CORAL REEF CHIROPRACTIC CENTER reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Policy Practices may be obtained by forwarding a written request to CORAL REEF CHIROPRACTIC CENTER at 9044 SW 152 Street, Miami, Florida 33157.

With this consent, CORAL REEF CHIROPRACTIC CENTER may call my home or other alternative location and leave a message on voicemail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointments reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, CORAL REEF CHIROPRACTIC CENTER 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.

With this consent, CORAL REEF CHIROPRACTIC CENTER may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that CORAL REEF CHIROPRACTIC CENTER restrict how it uses or discloses my PHI to carry out TPO. However, 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 CORAL REEF CHIROPRACTIC CENTER's use and disclosure of my PHI to carry out TPO.

I, the undersigned, hereby give CORAL REEF CHIROPRACTIC CENTER specific permission to post my name on a referral board in acknowledgement for the referral of new patients. The permission granted here excludes any health care related data, and is strictly limited to the use of my name in acknowledgement of referring a new patient to the practice.

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, CORAL REEF CHIROPRACTIC CENTER may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

ASSIGNMENT OF RIGHTS & BENEFITS (INSURANCE ONLY):

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to CORAL REEF CHIROPRACTIC CENTER, PA the professional or medical expense benefits allowable and otherwise payable to me under my insurance policy as payment toward charges for professional services rendered by this office.

A photocopy of this assignment shall be considered as effective and valid as the original for the duration of care and any additional time necessary to secure full payment for services rendered.

This assignment also permits the assignee to obtain from my insurance company all information necessary for the determination of benefits under the contract and permits the direct disclosure to assignee of all information, including benefits and reasons for denial of payment or reduction in changes for services rendered.

I also authorize this office to release any information pertinent to my case to any insurance company, adjustor, or attorney involved in my case and hereby release this office of any consequence thereof.

I agree to be financially responsible for all charges incurred by me at this office, including my insurance deductible, co-payment, and services rejected or not covered by my insurance company.

_____ _____ _____
Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian | Date

CORAL REEF CHIROPRACTIC CENTER, PA

TERMS OF ACCEPTANCE:

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they are both seeking and working for the same goals. Chiropractic has one goal. It is important that a patient understands this goal and the means that will be used to attain it. In this way there will be no confusion, misunderstanding or disappointment.

Patients usually want their conditions, ailments or symptoms treated. This is **NOT** the goal of the chiropractor. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine (the vertebrae). Tiny misalignments of the bones of the spine, which interfere with the function of the nerve pathways, are called **subluxations**. They come from many causes and prevent the body from working properly.

By means of a chiropractic adjustment, subluxations are corrected, restoring normal nerve function. The goal of chiropractic is to correct these subluxations so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency. With a proper nerve supply, health improves. In some, symptoms clear up quickly. For others, the process is slower; in some it is partial or not at all. Regardless of the disease, the chiropractor is not offering to heal, treat or cure it. His goal is to allow the body to do its job as best it can without nerve interferences. This goal is accomplished by the correction of the vertebral subluxation through adjustments.

The chiropractic examination and adjustment are not a substitute for other types of health care, just as other types of health care do not take the place of chiropractic.

_____

Signature of Patient or Legal Guardian

INFORMED CONSENT

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to: Broken Bones, Increased Symptoms and Pain, Dislocations, No Improvement of Symptoms or Pain, Sprains/Strains, or Worsening/Aggravation of Spinal Condition.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: Chiropractic Examination and Consultation, X-Rays (if necessary), Chiropractic Adjustment, and Exercises

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

_____ _____ _____

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian | Date