Elite Chiropractic & Wellness

2318 St Andrews Blvd - Panama City, Florida 32405 Office: (850)704-0008 Fax (850) 250-2582

CHIROPRACTIC PATIENT HISTORY

First Name_____Last Name: _____ Prefers to be Called_____
Date of Birth:_____Email Address: _____
Address: _____Apt # _____
City: _____State: _____ Zip: _____
Phone (H) _____ (W) _____(Cell) _____
Spouse's Name & Occupation _____ (Cell) _____
Your Occupation: _____ Employer: _____
Employer Address: _____
Insurance Company _____ Policy Number: _____
Emergency Contact Name and Phone Number:_____
Whom may we thank for referring you to our office?_____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT:_____

- Date when symptom first appeared: _____
- Did it begin: Gradual: _____Sudden: _____Progressive over time: _____
- What makes the symptoms worsen ? _____
- What makes the symptoms feel better? _____
- Type of Pain? Sharp _____Dull ____Ache _____ Burn_____ Throb _____ Other_____
- Does the Pain Radiate? Y or N if so where: Into your Arm R or L____Leg R or L Other_____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): Right Now_____ At Best_____ At Worst_____
- Are there any conditions or symptoms you have that may relate to your major symptom? _____

_____

What Activities of Daily Living make the problem worse? Sitting __ Standing __ Bending __Coughing __
Lying down ___ Walking __ Sneezing ___ Getting Dressed____ Exercising___ Sexual Activities____
Other (Please Explain) _____

OTHER COMPLAINT:_____

- Date when symptom first appeared: _____
- Did it begin: Gradual: _____Sudden: _____Progressive over time: _____
- What makes the symptoms worsen? _____
- What relieves the symptoms feel better? _____
- Type of Pain? Sharp _____Dull _____Ache _____ Burn_____ Throb _____ Other_____
- Does the Pain Radiate? Y or N if so where? Into your Arm R of L Leg R or L Other _____
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms? 100%_____ 75%_____ 50% _____ 25% _____ 10% _____
- PAIN INTENSITY: From 1 (Least) to 10 (worst): Right Now _____At Best_____ At Worst_____

What Activities of Daily Living make this problem worse? Sitting __ Standing __ Bending __Coughing __
Lying down ___ Walking __ Sneezing ___ Getting Dressed ___ Exercising____ Sexual Activities_____
Other _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE UNDERLINE ALL OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweating
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or Pain in
Arms, Hands, Legs
Allergy
Wheezing
Neuralgia

GASTROINTESTINAL SYMPT.
Poor Appetite
Difficult Digestion
Excessive Hunger
Belching of Gas
Nausea
Vomiting
Vomiting of Blood
Pain Over Stomach
Distention of Abdomen
Constipation
Diarrhea
Colon Trouble
Hemorrhoids (Piles)
Intestinal Worms
Liver Trouble
Gall Bladder Trouble
Jaundice
Colitis

E.E.N.T.
Failing Vision
Nearsightedness
Farsightedness
Crossed Eyes
Eye Pains
Deafness
Earache
Noises
Ear Discharge
Nose Bleeds
Nasal Obstruction
Sore Throat
Hoarseness
Hay Fever
Asthma
Dental Decay
Gum Trouble
Frequent Colds
Enlarged Thyroid
Nasal Drainage
Tonsillitis
Sinus Infection
Enlarged Glands

DESIRED WEIGHT: (Significantly Below, Below, Good, Over, Significantly Over)
Struggled Weight Patterns: (Most of life, last 10 years, Last 5 years, Within last year)
Moderate to significant Mental Health or Relational Stresses (Yes or No)

CARDIO-VASCULAR
Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Previous Heart Attack
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Previous Stroke

MUSCLE & JOINT SYMP.
Neck Pain
Low Back Pain
Swollen Joints
Tremors
Foot Trouble
Painful Tail Bone
Hernia
Spinal Curvature
Poor Posture

RESPIRATORY
Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficult Breathing

GENITOURINARY SYMPT.
Frequent Urination
Painful Urination
Bloody Urine
Pus in Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

SKIN
Skin EruptionsPainful
Itching
Bruising
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

FOR WOMEN ONLY
Painful Menstrual Periods
Vaginal Discharge
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Previous Miscarriage
Vaginal Discharge
Congested Breast
Lumps in Breast
Menopausal Symptoms
ANY CHANCE OF YOU BEING PREGNANT?
YES_____ NO_____

PATIENT SIGNATURE: _____

DATE: _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Name of treating physician: _____ Date of treatment: _____
Type of treatment or Drugs Prescribed _____

Please list all past surgeries:

Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____
Type_____ When_____ Doctor _____

Please list all previous accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking:

_____
_____
_____
_____

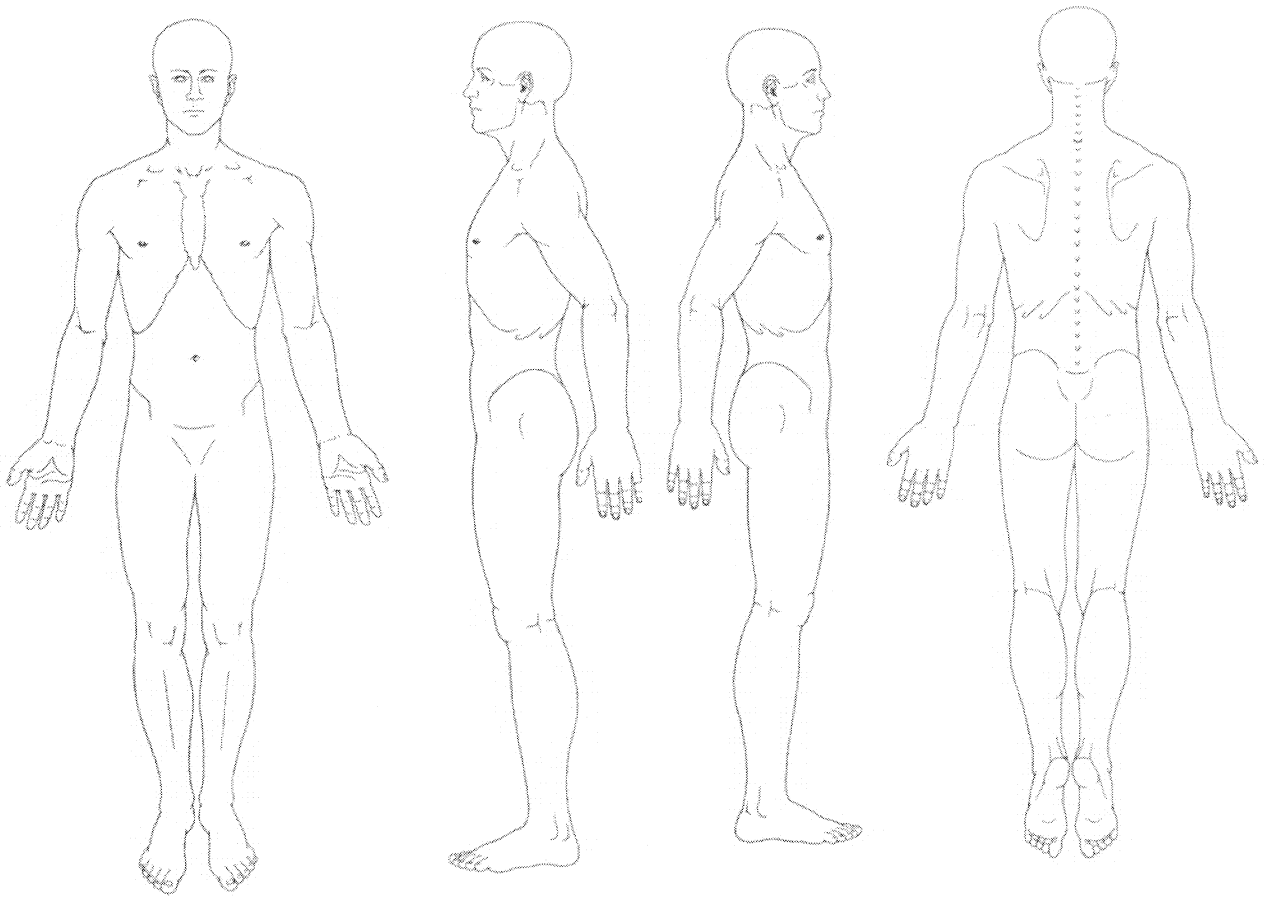
Please do not write in this section.

DOCTORS NOTES: _____
_____
_____
_____
_____
_____
_____

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

Patient Signature: _____ Date: _____

ELITE CHIROPRACTIC & WELLNESS

Release Of Records / Payment Agreement And Assignment Of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____ Date: _____

I hereby authorize: Elite Chiropractic & Wellness, my Health Care Provider/Facility, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records are without the expressed written consent of the patient or the patient's legal representatives.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to Elite Chiropractic & Wellness, my health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____ Date: _____

Witness: _____ Date: _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that the Chiropractic Office of Elite Chiropractic & Wellness' "Notice of Privacy Practices" is available to me upon request.

I understand I have a right to review the Chiropractic Office of Elite Chiropractic & Wellness' "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations, and describes my rights and the duties of the Chiropractic Offices of Elite Chiropractic & Wellness, with respect to my protected health information. This policy is also provided on request at the main administration desk of the practice.

The Chiropractic Office of Elite Chiropractic & Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

Name of Patient

Description of Personal Representative's Authority

Elite Chiropractic and Wellness

Informed Consent

Informed Consent To Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments and Care

I hereby request and consent to the performance of: physical examinations and evaluations required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical medicine, any associated nutrition supplements, home healthcare products, on me (or on the patient named below for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by **Elite Chiropractic & Wellness** , working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at any of the listed **Elite Chiropractic & Wellness.**

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose chiropractic adjustments and other procedures as well as home healthcare products and nutrition supplementation, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, sprains, swelling and bruising. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, what is in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at **Elite Chiropractic & Wellness**.

Intial Treatment Schedule: _____

ROF Doctor Signature _____

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

To be completed by patient's representative, if necessary, e.g., if patient is a minor or disabled

Patient Name: _____

Representative Name: _____

Signature of Representative: _____