FLORIDA SPINE GROUP
CONFIDENTIAL PATIENT CASE HISTORY

PATIENT INFORMATION

Today's Date_____ Social Security # _____ Date of Birth _____Age___

Name_____ Home Phone _____

Address _____ Cell Phone _____

City _____State_____ Zip _____ Work Phone_____

Email _____ Sex □ Male □ Female

Marital Status **M S W D**

Height_____' _____" Weight _____ lbs No. of Children _____ Ages _____

Occupation_____ Employer _____

Spouse Name_____ Spouse Occupation _____

Primary Care Physician _____ Phone _____

How were you referred to our office? _____ Have you had chiropractic care before? **Y/N**

If minor, name of parent of guardian _____

Who should we contact in case of emergency? _____

CURRENT COMPLAINTS

1. Please **circle** all that apply: **NECK** / **MID BACK** / **SHOULDERS** / **LOW BACK** / **ARMS** / **LEG** / **KNEE**
HEADACHES / **NUMBNESS** / **WEAKNESS**

Other Complaints: _____

2. How long have you had this condition? _____ Have you had this condition in the past? **Y/N**

3. Activities that are affected: □ **Work** □ **Sitting** □ **Caring for myself / family** □ **Walking** □ **Bending**
□ **Driving** □ **Sleeping** □ **Computer Work** □ **Stairs** □ **Housework**

4. Rate your **Pain** / **Dysfunction**: (LEAST) **1 2 3 4 5 6 7 8 9 10** (MOST)

5. Is this condition progressively getting worse? **Yes / No / Same**

6. How long has it been since you've really felt good? _____

7. Other Doctors you have seen for this condition: _____

8. List treatment, procedures, surgeries for this condition: _____

9. Have you had any of the following for this condition: MRI / CT scan / XRays / Injections

10. Has any other treatment helped? If so, what treatment? _____

11. What medications are you taking for this condition? _____

12. Is this condition due to an accident? If so, what type? _____

13. Have you been involved in an automobile accident within the □ Last year □ Five years □ Never

14. Date of last physical examination: _____ Doctor's Name: _____

HEALTH HISTORY (Check if current or in the past)

□ FREQUENT HEADACHES	□ FAINTING/SEIZURES/EPILEPSY	□ INSULIN
□ FREQUENT NECK PAIN	□ DIABETES	□ CANCER
□ LOWER BACK PROBLEMS	□ MITRAL VALVE PROLAPSE	□ ANEMIA
□ DISC PROBLEMS NECK/LOW BACK	□ HEART SURGERY OR PACEMAKER	□ SHINGLES
□ WHIPLASH	□ VENEREAL DISEASE	□ HIV/AIDS
□ NUMBNESS/TINGLING ARMS/LEGS	□ TUBERCULOSIS	□ HEPATITIS
□ SCOLIOSIS	□ EMPHYSEMA	□ ASTHMA
□ ARTHRITIS	□ PSYCHIATRIC PROBLEMS	□ OTHER
□ HEART ATTACK OR STROKE	□ KIDNEY PROBLEMS	_____
□ CONGENITAL HEART DEFECT	□ SINUS PROBLEMS	
□ ALCOHOL/DRUG ABUSE	□ DIFFICULTY BREATHING	
□ RHEUMATIC FEVER	□ ARTIFICIAL BONES/JOINTS	
□ HIGH/LOW BLOOD PRESSURE	□ HEART MURMUR	
□ ARTIFICIAL VALVES	□ ULCERS/COLINITIS	

FAMILY HISTORY

□ HEART DISEASE	□ HIGH BLOOD PRESSURE	□ STROKE
□ CANCER	□ DIABETES	□ SCOLIOSIS
□ OSTEOPOROSIS	□ OTHER _____	

ALLERGIES: Please list:

SURGICAL HISTORY: List surgeries and year performed:

SOCIAL HISTORY : Do you smoke? □ Yes □ No □ In the Past Alcohol use? □ Yes □ No

WOMEN ONLY Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

IMPORTANT INSURANCE INFORMATION

Is your condition due to an auto accident, job related injury or any form of accident? □ Yes □ No

Do you have health insurance? □ Yes □ No _____ (Insurance Company Name) _____ (Policy #)

Are you covered by Medicare? □ Yes □ No _____ (Medicare #) _____ (Secondary Ins.)

*****How will your first visit be paid?*** □ Check □ Cash □ Visa/MasterCard**

Patient or Legal Guardian Signature _____ **Date**_____

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name: _____

I hereby authorize payment to be made directly to **Florida Spine Group**, of all benefits which may be due and payable under insurance coverage for the above named Patient. I authorize utilization of this application of copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to **Florida Spine Group**.

Furthermore, I hereby **IRREVOCABLY ASSIGN** to **Florida Spine Group**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida Statutes for any service and or charges provided by **Florida Spine Group**.

Patient or Authorized Signature X **Date**

FINANCIAL POLICY

I understand that I am fully responsible for payment of all charges, including but not limited to, deductibles and copayments related to my care. I understand that my balance should **not exceed $200.00** at any given time; **Florida Spine Group** does not mail monthly statements to patients. If my balance is not paid in a monthly or timely fashion, I promise to pay any and all collections, court and attorney's fees in the collection of my account. I further understand that if my Insurance Company or Medicare declines payment, or does not pay services within 45 days of the date rendered, I will pay upon notice, to **Florida Spine Group,** any balance due upon my account.

Patient or Authorized Signature X **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have read a copy of **Florida Spine Group's** notice of **Patient Privacy Practices**.

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 of your Patient Health Information**, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Patient or Authorized Signature X **Date**

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to **Florida Spine Group**. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

In addition, I have read and agree to the above **Assignments, Financial Policies, Notices, Releases and Consent forms and acknowledge Florida Spine Group does NOT accept or participate in any HMO's**.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Patient or Authorized Signature X **Date**

Patient or Authorized Signature

FLORIDA SPINE GROUP

Patient Name _____ Date _____

CHIROPRACTIC INFORMED CONSENT

"Chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Florida Statute 460.403(3)(b)

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. *See* Fla. Stat. 460.403(9)(a). Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. *See* Fla. Stat. 460.403(9)(a)

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, spinal injury, stroke, vision disturbances and others. The most common side effect following chiropractic manipulation/adjustment is an ache or stiffness at the site of the adjustment.

I, also hereby give authorization for **consent of treatment** to **Florida Spine Group** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, physical therapy and therapeutic modalities such as heat, ice, ultrasound, stimulation, traction, muscle stimulation and others treatments by **Florida Spine Group**. **All of my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X **Date**

FLORIDA SPINE GROUP
ASSESSMENT OF ACTIVITIES OF DAILY LIVING

Patient Name_____ **Date**_____

Standing

- □ Able to stand as long as desired without pain
- □ Able to stand for 60 minutes without pain
- □ Able to stand for 45 minutes without pain
- □ Able to stand for 30 minutes without pain
- □ Able to stand for 25 minutes without pain
- □ Able to stand for 15 minutes without pain
- □ Able to stand for 10 minutes without pain
- □ Able to stand for 5 minutes without pain
- □ Unable to stand at all due to pain

Bending

- □ Able to bend as far as would like without pain
- □ Able to bend 80 degrees without pain
- □ Able to bend 70 degrees without pain
- □ Able to bend 60 degrees without pain
- □ Able to bend 50 degrees without pain
- □ Able to bend 40 degrees without pain
- □ Able to bend 30 degrees without pain
- □ Able to bend 20 degrees without pain
- □ Able to bend 10 degrees without pain
- □ Unable to bend at all due to pain

Driving

- □ Able to drive when necessary without pain
- □ Able to drive for 120 minutes without pain
- □ Able to drive for 90 minutes without pain
- □ Able to drive for 60 minutes without pain
- □ Able to drive for 45 minutes without pain
- □ Able to drive for 30 minutes without pain
- □ Able to drive for 20 minutes without pain
- □ Able to drive for 10 minutes without pain
- □ Unable to drive at all due to pain

Walking

- □ Able to walk as far as desired without pain
- □ Able to walk 2-3 miles without pain
- □ Able to walk 1 mile without pain
- □ Able to walk ½ mile without pain
- □ Able to walk ¼ mile without pain
- □ Able to walk 1 block without pain
- □ Able to walk 100 feet without pain
- □ Able to walk 50 feet without pain
- □ Unable to walk at all due to pain

Picking up Objects

- □ Able to pick up heavy objects without pain
- □ Able to pick up 45 pounds without pain
- □ Able to pick up 35 pounds without pain
- □ Able to pick up 25 pounds without pain
- □ Able to pick up 20 pounds without pain
- □ Able to pick up 15 pounds without pain
- □ Able to pick up 10 pounds without pain
- □ Able to pick up 5 pounds without pain
- □ Unable to lift anything due to pain

Sitting

- □ Able to sit without pain
- □ Able to sit 8 hours without pain
- □ Able to sit 7 hours without pain
- □ Able to sit 6 hours without pain
- □ Able to sit 5 hours without pain
- □ Able to sit 4 hours without pain
- □ Able to sit 3 hours without pain
- □ Able to sit 2 hours without pain
- □ Able to sit 1 hour without pain
- □ Able to sit 30 minutes without pain
- □ Unable to sit at all due to pain

Housework

- □ Able to do housework for 90 minutes without pain
- □ Able to do housework for 80 minutes without pain
- □ Able to do housework for 70 minutes without pain
- □ Able to do housework for 60 minutes without pain
- □ Able to do housework for 50 minutes without pain
- □ Able to do housework for 40 minutes without pain
- □ Able to do housework for 30 minutes without pain
- □ Able to do housework for 20 minutes without pain
- □ Able to do housework for 10 minutes without pain
- □ Unable to do housework at all due to pain

Headaches

- □ Having no headaches
- □ Having 2 headaches per month
- □ Having 1 headache per month
- □ Having 1 headache per day
- □ Having 5 headaches per week
- □ Having 3-4 headaches per week
- □ Having 1-2 headaches per week
- □ Having constant headaches

Opening Jars

- □ Able to open any jar without pain
- □ Able to open very tight jars without pain
- □ Able to open medium tight jars without pain
- □ Able to open lightly closed jars without pain
- □ Unable to open any jar due to pain

Lying Down

- □ Able to lay as long as would like without pain
- □ Able to lay for 120 minutes without pain
- □ Able to lay for 90 minutes without pain
- □ Able to lay for 60 minutes without pain
- □ Able to lay for 30 minutes without pain
- □ Able to lay for 20 minutes without pain
- □ Able to lay for 10 minutes without pain
- □ Unable to lay at all without pain

Patient Signature_____

Physician Signature_____

REVIEW OF SYSTEMS - FLORIDA SPINE GROUP

Do you have: (please check all that apply):

Constitutional:
□Fevers □Weight loss □Difficulty sleeping □Tiredness or fatigue □Chills □Night sweats □**None**

Eyes:
□Flashing lights or "stars" □Blind spots □Double vision □**None**

Ears, Nose, Throat, Mouth:
□Earache or discharge □Ringing in ears □Difficulty hearing □Nose bleeds □Sinusitis □Hoarseness □Sores in mouth □Sore throats □**None**

Cardiovascular:
□Chest pain □Squeezing or tightness in chest □ Angina □Need to sleep with head of the bed elevated
□Cramps in buttocks, thighs or calves when walking □Shortness of breath at rest or walking/climbing
□Palpitations or fluttering heart □Poor circulation □Gangrene □Swelling of hands, face, legs or feet □High cholesterol □**None**

Respiratory:
□Cough □Sputum production □Coughing up blood □Pleurisy □Wheezing □Asthma □**None**

Gastrointestinal:
□Nausea or vomiting □Diarrhea □Constipation □Abdominal pain □Vomiting of blood □Very dark or light stool
□Jaundice □Liver or gall bladder problems □Colitis or other bowel problems □Bleeding from rectum □Ulcer
□**None**

Genitourinary:
□Blood in urine or very dark urine □Get up at night to urinate □Burning with urination □Unusual urgency to urinate □Difficulty in getting urine stream started □Kidney stones □Prostate problems □Bladder problems
□Albumin or protein in urine □Pus in urine □Infection in urine □Large amounts of urine or very frequent urination
□**None**

Musculoskeletal:
□Low back pain □Neck pain □Muscle ache □Joint pain □Mid back pain □Shoulder/arm pain □Hip/leg pain
□Arthritis □**None**

Neurological:
□Headaches □Drooping of face □Loss of strength in hands, arms, legs, feet □Numbness/tingling □Seizures
□Loss of consciousness □Dizziness □Fainting spells □**None**

Skin:
□Rashes □Skin ulcers □Nodules on skin □**None**

Emotional/Psychiatric:
□Depression □Anxiety □Psychiatric problems □**None**

Endocrine:
□Enlarged thyroid □Sweating □Diabetes □Excess thirst □Change in appetite □Feeling unusually hot or cold
□Flushing □Abnormal menses □Post-menopausal □**None**

Hematologic/Lymphatic/Oncologic:
□Anemia □Iron deficiency □Enlarged lymph glands □Easy bruising □Cancer □**None**

Allergic/Immunologic:
□Hay fever □Seasonal allergies □Other_____ □**None**

_____ _____ _____
Patient Signature **Date** **Physician Signature**