Information provided on this form is confidential. Please fill in ALL portions of the form with complete and accurate information so we can assist you properly during your healing process.

Name: ____ **Date:** ______________

Address:____

City: ______________________________ **State:** _________ **Zip:** _________________

Home Phone #: ________________ **Work #:** _________________ **Cell #:** _______________

Preferred method of contact: **Home** **Work** **Cell** **E-mail:** _________________________

Drivers License #: ____________________________ **SS#:** _______ - ______ - __________

Date of Birth: __________________ **Age:** ______ **Employed By:** ________________________

Primary Healthcare Provider:_____________________ **Date of last physical exam:** __________

Marital Status: **Married** **Partnered** **Single** **Divorced** **Widowed**

Spouse/Partner Name: _____________________ **Employed By:** _______________________

How did you find out about us? (If referred by a person, feel free to tell us their name so we can thank them!)

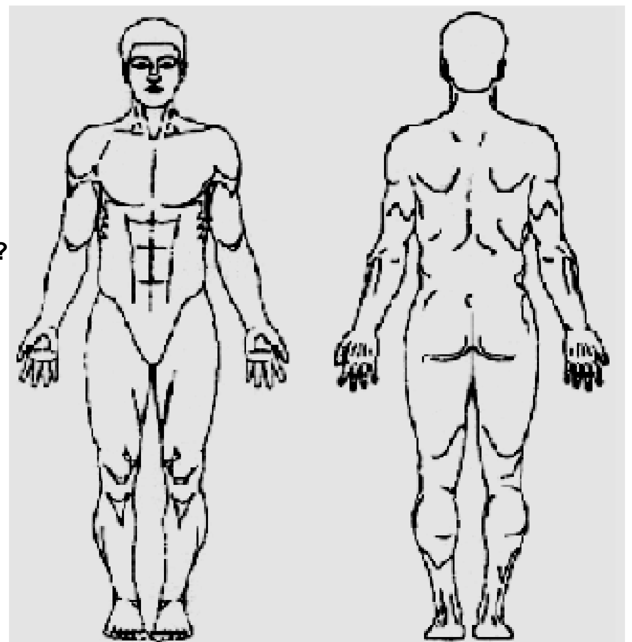
____

PROBLEM / CONDITION

1. Is today's problem caused by: ☐ Auto Accident

(check if appropriate) ☐ Workman's Compensation

2. Where is the problem? (circle/mark on the diagram)



3. How often do you experience your symptoms (as a % of the time)?

☐ Constantly (76-100%) ☐ Occasionally (26-50%)

☐ Frequently (51-75%) ☐ Intermittently (1-25%)

4. How would you describe the type of pain?

- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Stiff
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric like with motion
- □ Other:________________

Patient Name: ___________________________

5. How are your symptoms changing with time?

☐ Getting Worse ☐ No Change ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst),
how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: ______________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ______________________

11. How do you think your problem began?
____

12. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?
____

14. What helps your problem?
____

15. How does your problem affect your daily living?____

CURRENT & PAST HEALTH

16. What is your: Height:_________ Weight:___________ Date of Birth:_____________
Occupation:_________________________

17. How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

18. What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. Are you pregnant? ☐ **No** ☐ **Yes – Due Date: ___________________**

20. Do you smoke? ☐ **No** ☐ **Yes – Amount per week: ________________**

21. Do you drink alcohol? ☐ **No** ☐ **Yes – Amount per week: ________________**

22. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

23. For each of the conditions listed, check the boxes if you have had the condition in the past or currently have the condition.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite			**For Females Only**

Patient Name: ________________________________

◻	◻	Jaw Pain	◻	◻	Abdominal Pain	◻	◻	Birth Control Pills
◻	◻	Joint Pain/Stiffness	◻	◻	Ulcer	◻	◻	Hormonal Replacement
◻	◻	Arthritis	◻	◻	Hepatitis	◻	◻	Pregnancy
◻	◻	Rheumatoid Arthritis	◻	◻	General Fatigue			
◻	◻	Tumor	◻	◻	Muscular Incoordination			
◻	◻	Asthma	◻	◻	Visual Disturbances			
◻	◻	Chronic Sinusitis	◻	◻	Dizziness			
◻	◻	Other:___________________________						

24. List any significant family illnesses (e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis, etc.)

Mother: ____ **Father:** ____

Siblings: ____

Grandparents: ____

24. List any medication allergies: ____

25. List all prescription medications you are currently taking: ____

26. List all of the supplements and over-the-counter (OTC) medications you are currently taking:

____

27. List all surgical procedures you have had: ____

28. What activities do you do at work?

☐ **Sit:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Stand:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Computer work:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **On the phone:**	☐ Most of the day	☐ Half the day	☐ A little of the day

29. What activities do you do outside of work? ____

30. Have you ever been hospitalized? ☐ No ☐ Yes – if yes, what? ________________________________

31. Have you had significant past trauma? ☐ No ☐ Yes – if yes, what? ________________________________

32. Is there anything else you would like the doctor to know? ____

33. Are you concerned about your overall wellness? ☐ No ☐ Yes

34. Are you interested in learning about our nutrition programs? ☐ No ☐ Yes

35. Are you interested in utilizing our state-of-the-art technology for the enhancement of self-image?

☐ laser hair removal ☐ spider vein removal ☐ facial rejuvenation ☐ acne treatment ☐ pigment (sun induced/age spot) removal

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I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I hereby authorize the release of any medical information or other information to process claims for payment. I hereby authorize and direct my attorney to pay directly to Florida Wellness and Rehab such sums as may be due and owing for medical service rendered to me both by reason of an accident and by reason of any other bills that are due to this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Florida Wellness & Rehab.

Payment should be mailed to : Florida Wellness and Rehab, 101 N. Franklin St., Ste. A, Tampa, FL 33602

Patient Signature_____________________________________ **Date:**_____________________

Patient Name: _________________________________

ASSIGNMENT OF BENEFITS

I, ______________________ authorize ___________________________ to make medical
(Patients name) (Insurance Company)
Benefits payments otherwise payable to me for services rendered by Florida Wellness and Rehab but not to exceed the charges of those services, payable to and mailed directly to

Florida Wellness & Rehab, P.A.
101 N Franklin St
Suite A
Tampa, FL 33602

I hereby instruct the insurance carrier that in the event that the subject medical benefits are disputed and/or reduced for any reason, including medical reasonableness and/or necessity, that the amount of the unpaid benefits claimed by Florida Wellness and Rehab is to be set aside and not disbursed until the dispute is solved.

Furthermore, I hereby irrevocably assign to Florida Wellness and Rehab the right and benefits and any and all causes of action resulting from any reduction and/or nonpayment under any policy of insurance, indemnity agreement or any other collateral source as defined by Florida Statutes for any service and/or charges provided by Florida Wellness and Rehab.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this ________ day of _______________________, 201__.

_____________________________________. _______________________________
(Patient name – printed) (Patient signature)

_____________________________________.
(Provider Signature)

Insurer: ____

Policy #: ____

INFORMED CONSENT

In consideration of your undertaking to treatment, I agree to the following:

Assignment of Benefits: I direct my insurance carrier to pay directly to Florida Wellness & Rehab, PA, any benefits due to it as a result of this claim.

Personal Responsibility for Charges: I understand that I am personally responsible for charges and/or balances not covered by insurance payments or settlements.

Senior Adults: Medicare will NOT, in most cases, pay for deductible, therapies or x-rays done by a Chiropractor, or for certain procedures performed by a medical doctor. You will be responsible for a reasonable charge for these services. Most Medicare patients have a $100 annual deductible.

Release of Information: I authorize Florida Wellness & Rehab to discuss my case and release office notes, x-rays and other records to doctors, insurance companies, adjusters, and those named here:

____

Consent for Treatment: I am seeking Medical treatment from Florida Wellness & Rehab, and consent to receiving this treatment for my minor child or myself.

Chance of Injury: I understand that there is some risk with any procedure, medical, acupuncture, or chiropractic. Although there is some change of soreness or stiffness after an initial adjustment, the chance of serious injury is very small. However, in very rare cases, a person can experience injury to a disc, ribs or spine.

ATTENTION FEMALE PATIENTS: In the event that x-rays are needed, please advise the doctor at this time if you are or have reason to believe you may be pregnant.

Date:____________________________________

Signed:___________________________________

Print Name:_______________________________

Parent/Guardian of :________________________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________________________date____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Thank you for letting your voice be heard for chiropractic!

By signing up you will keep chiropractic a vital part of healthcare policy. In the future, you will receive a monthly electronic newsletter with valuable information, health tips, and articles of interest to you. We know that chiropractic is an important aspect of your overall health care, so we will also keep you informed about federal and state policies that might affect your access to chiropractic services.

Please complete the form below to begin enjoying the benefits of free membership today.

All information you provide will remain private; it will not be sold or distributed to unaffiliated third parties

First Name: ____

Last Name: ____

Address: ____

City: ____

State: ____

Zip: ____

Phone: ____

Email: ____

THIS FORM IS VOLUNTARY, BUT PROVIDES GREAT INFORMATION AND ALSO TAKES STRIDES TO ENSURE CHIROPRACTIC BENEFITS STAY ACCESSIBLE TO ALL PATIENTS.

New Cancellation / Change Policy
Effective February 1, 2009

To maintain the integrity and efficiency of office operations, effective February 1, 2009, all cancellations or changes to appointments made within 24-hours of the scheduled time are subject to a $30 fee.

Thank you for your understanding in this matter.

Florida Wellness & Rehab

Accepted and Acknowledged:

____
Print Patient Name

____
Signature

____
Date