



F L O R I D A
WELLNESS & REHAB

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: _____ Preferred Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Preferred method of contact: Home Work Cell E-mail: _____

Can we leave a confidential Message? Yes No

Drivers License #: _____ SS#: _____ - _____ - _____

Date of Birth: _____ Age: _____ Employed By: _____

Marital Status: Married Partnered Single Divorced Widowed Separated

Spouse/Partner Name: _____ Employed By: _____

Primary Healthcare Physician: _____ Date of last physical exam: _____

Primary Dental Physician: _____ Date of last dental visit: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Pharmacy: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Have you completed advanced directives? Yes No A living will? Yes No

How did you find out about us?

What brings you to our office today? Please list all reasons:

1 - Is today's problem due to: Auto Accident: Yes No

Worker's Compensation: Yes No

Patient Name: _____

7 - Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
- ER physician Orthopedist Other: _____
- Massage Therapist Physical Therapist No one

8 - How long have you had this problem? _____

9 - How do you think your problem began? _____

10 - Do you consider this problem to be severe? Yes Yes, at times No

11 - What aggravates your problem? _____

12 - What helps your problem? _____

13 - Are you experiencing any weakness? Yes No **If so, where:** _____

14 - How does your problem affect your daily living? _____

15 - Social and Wellness History

What is your height right now? _____

What is your weight now? _____ One year ago? _____ Maximum? _____ When? _____

Who do you live with (include all family members, friends and pets): _____

Occupation and Enjoyment Level (please be specific): _____

List exercise and hobbies? (include frequency) _____ .

Nutrition: 1 serving=1/2 cup How many fruits/vegetables do you eat per day? _____

What beverages do you consume in a day? (Specify amount in cups, 8 ounces=1 cup)

- Water _____ Diet Soda _____ Regular Soda _____ Iced Tea _____ Milk _____ Other _____

Tobacco/Alcohol/Drugs:

Are you using: Cigarettes Cigar Chewing Tobacco Pipe Amount/day _____ #years _____

Do you drink alcohol? Yes / No. If yes, give amount and how often (1 serving=1.5 ounce hard liquor, 12 ounce can of beer, 5 ounce of wine) _____

Do you use marijuana, cocaine, heroin, speed, crack, or other inhalants? Yes / No.

If yes explain (include amount, how often, route taken) _____

If used in past, explain _____

Do you feel you have a drinking, drug or tobacco problem? Yes No

If yes explain: _____. Do you need help quitting? Yes No. If yes, what would you be interested in doing? _____

Have you had sexual relations with? male female both

How many sexual partners have you had in a year? _____

Personal Safety

Do you feel safe at home? Yes No

Patient Name: _____

16 - Past Medical History

Have you ever had or been diagnosed to have (include date diagnosed and who diagnosed you):

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Cataracts _____ |
| <input type="checkbox"/> Diabetes / Pre-Diabetes _____ | <input type="checkbox"/> Glaucoma _____ |
| <input type="checkbox"/> Abnormal Cholesterol _____ | <input type="checkbox"/> Seizures/Epilepsy _____ |
| <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Hemorrhoids _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Heart Attack/Angina _____ | <input type="checkbox"/> Heart Murmur _____ |
| <input type="checkbox"/> Ulcers/Heartburn _____ | <input type="checkbox"/> Anemia/Tranfusion _____ |
| <input type="checkbox"/> Abdominal Disorder _____ | <input type="checkbox"/> Bleeding Disorder – specify: _____ |
| <input type="checkbox"/> Lung Disease (COPD) _____ | <input type="checkbox"/> Jaundice/Liver/Gallstones _____ |
| <input type="checkbox"/> Headaches - <input type="checkbox"/> Migraines or <input type="checkbox"/> Tension? | <input type="checkbox"/> Frequent Infection – specify: _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Chicken Pox _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> HIV or Syphilis _____ |
| <input type="checkbox"/> Bone or Joint Disease _____ | <input type="checkbox"/> Blood Clot – where/when: _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Cancer – type/when: _____ |
| <input type="checkbox"/> Prostate Enlargement _____ | <input type="checkbox"/> Other: _____ |

17 - Systems Review

Please check those items that have been a problem for you.

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| | | Constitutional Symptoms | | | Respiratory |
| <input type="checkbox"/> | <input type="checkbox"/> | Good Health Lately | <input type="checkbox"/> | <input type="checkbox"/> | Chronic or frequent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent significant weight change | <input type="checkbox"/> | <input type="checkbox"/> | Coughing or spitting up blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual fatigue or weakness | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Adequate sleep | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or recurrent wheezing |
| | | Eyes | | | Skin/Breast |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in Vision | <input type="checkbox"/> | <input type="checkbox"/> | Rashes or itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred or double vision | <input type="checkbox"/> | <input type="checkbox"/> | Change in skin color or moles |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye disease or injury | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses/contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | Breast pain |
| | | Ears/Nose/Mouth/Throat/Neck | <input type="checkbox"/> | <input type="checkbox"/> | Breast lump |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear hearing aids? | <input type="checkbox"/> | <input type="checkbox"/> | Breast discharge or rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss or ringing in ears? | | | Neurological |
| <input type="checkbox"/> | <input type="checkbox"/> | Earaches or drainage | <input type="checkbox"/> | <input type="checkbox"/> | Frequent, recurrent or increasing headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinus problems or runny nose, or frequent colds? | <input type="checkbox"/> | <input type="checkbox"/> | Light-headedness or dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | ___ # colds / year | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions, seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | ___ # sinus infections / year | <input type="checkbox"/> | <input type="checkbox"/> | Persistent numbness or tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> | Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat/hoarseness | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps or swollen glands in neck | <input type="checkbox"/> | <input type="checkbox"/> | Head injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing | | | Gastrointestinal |
| | | Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Change in bowel movements |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Frequent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack or angina pectoris | <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding or blood in stool |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/abdominal pains or heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath with walking or lying flat | <input type="checkbox"/> | <input type="checkbox"/> | Black or tarry stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling feet, ankles or hands | <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Waking at night with shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Painful bowel movements / Constipation |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Other Abdominal Disorder |

Patient Name: _____

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Genitourinary |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning or pain on urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in force or strain when urinating |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence or dribbling of urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | Men: Testicular pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Women: Decreased Libido |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful or Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |

Musculoskeletal

- | | | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain, stiffness, swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness of muscles or joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain or recurrent cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant cold hands &/or feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in walking |

Psychiatric

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Memory loss or confusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness or anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression or Bipolar |

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Cont'd |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual or physical abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Thoughts of hurting self or other |

Endocrine

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glandular or hormone problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive skin dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst or urination |

Hematologic/Lymphatic

- | | | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant Bleeding or bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood thinners (aspirin, aleve) |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent anemia |

Women Only

Number of pregnancies (include miscarriages):
 _____ # Deliveries _____ # Miscarriages

Currently Pregnant: Yes / No

Method of birth control: _____

Menopausal since: _____

Date of last menstrual period: _____

Date of last pap smear: _____

Abnormal pap Y / N When? _____

Treatment: _____ Doctor treating: _____

Do you do Hormone Replacement: Yes / No

18 - Family Medical History

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

	Age	Major Health Issues	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or sisters (specify)					
Spouse					
Children					

Has any blood relative ever had? (if Yes, indicate relationship)

- | | | |
|--|---|---|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Heart attack before age 55 _____ | <input type="checkbox"/> alcoholism _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> bleeding disease _____ | <input type="checkbox"/> allergies _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> stroke _____ | <input type="checkbox"/> asthma _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> seizures _____ | <input type="checkbox"/> migraines _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> thyroid _____ | <input type="checkbox"/> high cholesterol _____ |
| <input type="checkbox"/> Mental disorder (depression/suicide/anxiety) _____ | | |
| <input type="checkbox"/> Cancer (type of cancer, who had and when diagnosed) _____ | | |

Patient Name: _____

19 - Medical Information

Allergies & Reactions: (include all allergies) / No Known allergies (check here) _____

Medications List all prescriptions, herbal supplements, vitamins, creams, nose sprays, eye drops, etc

Name	Dose	Frequency	Reason	Physician	How Long?

Operations: List all surgical procedures

Hospitalizations: other than operations

Year	Procedure	Year	Reason	Hospital

Immunization History (check if yes and indicate year of last injection)

- Influenza _____
 Pneumonia _____
 MMR _____
 Tetanus _____
 Hepatitis A or B _____
 Other _____

Specialists You Frequent

Name	Specialty	Reason	Last seen

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: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Social Security Number: _____

Prior Practice Name and Location: _____

I authorize the health information to be disclosed to and used by the following individual organization:

Office of Florida Wellness & Rehab
Dr. Tanya Gold, MD / Dr. Edward Leonard, DC / Dr. Holly Ridge, DC
101 N. Franklin St. Ste. A
Tampa, FL 33602
Phone: 813-229-2225
Fax: 813-221-2225

The type and amount of information to be disclosed is as follows (as applicable):

Last TWO Progress Notes, Complete Vaccination Record, All Laboratory Results, Latest Colonoscopy and EGD with reports, Most recent EKG, Most recent stress test, and Last complete physical and complete listing of current medications.

For women, please include most recent pap smears, mammograms, breast ultrasound, breast MRI, and breast biopsy with diagnosis (if done).

Any abnormal EKGs, stress tests, or other abnormal test results.

Other: _____

1. The medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
2. This authorization will expire without my express revocation, 180 days from the date hereof, unless otherwise specified. If I am a minor, on the date I become an adult according to state law.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. My treatment, payment, enrollment or eligibility for benefits may not be conditions on signing this authorization.
5. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation.
6. A copy of this authorization or my signature thereon, may be utilized with the same effectiveness as an original.

Signature of Patient or Authorized Personal Representative

Date

Printed Name of Patient or Authorized Personal Representative

Relationship to Patient

Patient Name: _____



F L O R I D A
WELLNESS & REHAB

813.229.2225

floridawell.com

101 N. Franklin St. Ste. A | Tampa FL, 33602

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.

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