



INDIALANTIC CHIROPRACTIC & ACUPUNCTURE, INC.
322 FOURTH AVENUE, INDIALANTIC, FL 32903
CHIROPRACTIC CASE HISTORY

NAME: _____ SEX: M F DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

H. PHONE: (____) _____ W. PHONE: (____) _____ C. PHONE: (____) _____

SECONDARY ADDRESS/PHONE: _____

DOB: _____ EMAIL: _____

REFERRED BY: _____ SOCIAL SECURITY #: _____ (Marital Status)
S M D W

OCCUPATION: _____ EMPLOYER _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

ARE YOU INTERESTED IN ACUPUNCTURE, CHIROPRACTIC OR WHAT THE DOCTOR FEELS NECESSARY?

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? YES NO IF YES, WHEN? _____

1. PRIMARY REASONS FOR SEEKING CHIROPRACTIC/ACUPUNCTURE CARE: _____

HAVE YOU HAD AN X-RAY, MRI, NCS, EMG, BLOOD TEST TO HELP DIAGNOSE THIS CONDITION? IF YES,
WHERE? _____

2. OTHER COMPLAINTS: _____

LOCATION OF COMPLAINT: _____

COMPLAINT BEGAN WHEN AND HOW? _____

PLEASE CIRCLE THE QUALITY OF THE COMPLAINT/PAIN: DULL, ACHING, SHARP, SHOOTING, BURNING,
THROBBING, DEEP NAGGING, OTHER _____

DOES THIS COMPLAINT/PAIN RADIATE OR TRAVEL (SHOOT) TO ANY AREAS OF YOUR BODY? _____

WHERE? _____ DO YOU HAVE ANY NUMBNESS/TINGLING IN YOUR BODY? _____

WHERE? _____

GRADE INTENSITY/SEVERITY (NO COMPLAINT/PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST POSSIBLE PAIN)

HOW FREQUENT IS COMPLAINT PRESENT, HOW LONG DOES IT LAST? _____

DOES ANYTHING MAKE IT BETTER OR WORST? _____



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3. PREVIOUS TREATMENTS, MEDICATIONS, SURGERY, OR CARE YOU'VE SOUGHT FOR YOUR

COMPLAINT: _____

HAVE YOU HAD ANY COLON, HEART, LUNG, URINARY CHANGES? IF SO, WHAT? _____

4. PAST HEALTH HISTORY:

A. PREVIOUS ILLNESSES YOU'VE HAD IN YOUR LIFE: _____

B. PREVIOUS INJURY OR TRAUMA: _____

HAVE YOU EVER BROKEN ANY BONES? WHICH? _____

C. ALLERGIES _____

D. MEDICATIONS:	REASON FOR TAKING
_____	_____
_____	_____
_____	_____

E. SURGERIES:	TYPE OF SURGERY
_____	_____
_____	_____

5. FAMILY HEALTH HISTORY:

A. ASSOCIATED HEALTH PROBLEMS OF RELATIVES: _____

B. DEATH IN IMMEDIATE FAMILY AND CAUSE:	AGE
_____	_____
_____	_____

6. SOCIAL & OCCUPATIONAL HISTORY:

A. JOB DESCRIPTION: _____

B. RECREATIONAL ACTIVITIES: _____

C. TYPE OF INSURANCE (EX. AETNA, BCBS, ETC): _____

I have read the above information & certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic/acupuncture care, in accordance with this state's statutes.

Patient/Guardian Signature _____
Date



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INFORMED CONSENT TO CHIROPRACTIC/ACUPUNCTURE TREATMENTS

Doctors of Chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients there are or may be risks associated with such treatment. Chiropractic care: including spinal adjustments, physiotherapy and acupuncture have been subject to government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatments for spinal pain, headaches and other symptoms. Chiropractic/Acupuncture care can contribute to your overall well-being. The risk of injuries or complications from these treatments is substantially lower than that associated with many other medical treatments, medications, and procedures given for the same symptoms.

A) I understand with Chiropractic manipulation I may experience soreness or pain following treatment, just as one would after exercise or other strenuous activity. While rare, some patients in chiropractic offices have experienced injuries, such as rib fracture, disc inflammation, muscle or ligament strains or sprains following spinal manipulation or adjustments. I understand I should advise the Chiropractic physician of any medical conditions that may pre-dispose me to fracture or dislocation, as the physician may alter my treatment to include other therapies.

B) I understand I should advise the physician of any allergies such as stainless steel, tape, adhesives, gels, herbs or supplements, in advance of treatment. It is my responsibility to advise the physician of any artificial implants such as breast, or joint replacements, or electrical implants such as pacemakers, etc prior to treatment.

C) I understand acupuncture may cause swelling, bleeding or bruising over the insertion areas. This is normally a temporary situation.

D) I understand if I experience any unusual symptoms following treatment that I should contact the Chiropractic Physician immediately.

I acknowledge I have read the contents of this consent notice and will be given the opportunity to discuss with my chiropractic/acupuncture physician regarding the nature and purpose of chiropractic/acupuncture treatments in general, as well as my treatment in particular. I consent to the treatment offered or recommended by the physician, including chiropractic, and/or acupuncture for my present and future care.

(Print Name)

Date

(Signature)

IMPORTANT READ

We are required by State of Florida law to take a history and examination regardless if this is a one time visit or not. Insurance carriers will not "guarantee" payment of benefits. We bill your insurance as a courtesy and until benefits are determined by carrier payment, **I understand I am responsible for fees**. We will reimburse **or** apply as credit to your account any portion recovered from your insurance carrier. Some Insurance carriers (ex. Medicare) will **not** pay for the history and examination; **I understand this fee is my responsibility at time of service**. We bill secondary carriers as a courtesy; **I understand I am responsible to pay my fees** until your insurance carrier remits payment.

I have read the above statements and agree to examination, agree to provide a full history and to discuss treatment options with the doctor prior to initiating treatment.

_____ initial(s)



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I was provided a copy of the Notice of Privacy Practices and I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand the Notice of Privacy Practices is located at the Chiropractic Office and is available during office hours for reading. I understand this form will be placed in my patient chart and maintained for six years.

Patient Name (Print)

Date

Parent or Guardian/Legal Representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S FILE AND MAINTAINED FOR A PERIOD OF SIX YEARS.