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

CHIROPRACTIC CASE HISTORY

NAME: _____ DATE:_____

ADDRESS: _____ CELL: (____)_____

_____ SERVICE PROVIDER:

☐ AT&T ☐ Verizon ☐ Sprint ☐ T-Mobile ☐ Metro
☐ Virgin ☐ US Cell ☐ Cingular ☐ Boost

CITY: _____ STATE:_____ ZIP:_____

GENDER: ☐ Male ☐ Female

HOME: (____)_____

DATE OF BIRTH: _____

WORK: (____)_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow

EMAIL: (____)_____

EMPLOYER:_____

REFERRED BY: _____

INSURANCE PROVIDER: _____

EMERGENCY CONTACT INFORMATION

PRIMARY PHYSICIAN: _____

NAME:_____

MAY WE CONTACT YOUR PHYSICIAN? ☐ Yes ☐ No

PHONE NUMBER: _____

Reason for Visit

☐ Chronic Condition ☐ Wellness/Maintenance ☐ Injury
☐ Automobile Accident ☐ Trauma ☐ Other_____

Pain Diagnostic Questions

HOW/WHEN DID YOUR PAIN BEGIN? _____

WHERE ARE YOU EXPERIENCING THIS PAIN? _____

CHECK THE DESCRIPTION(S) WHICH BEST MATCHES THE KIND OF PAIN YOU ARE EXPERIENCING:

☐ DULL ☐ ACHING ☐ SHARP ☐ SHOOTING
☐ BURNING ☐ THROBBING ☐ DEEP NAGGING ☐ OTHER _____

PAIN GRADE INTENSITY SCALE (0=None,10=Most)

0	1	2	3	4	5	6	7	8	9	10

HOW FREQUENT IS PAIN PRESENT?

☐ NOT OFTEN ☐ REGULARLY. BUT COMES AND GOES ☐ ALL THE TIME ☐ NO PAIN AT ALL

HOW LONG DOES IT LAST? _____

DOES ANYTHING MAKE THE PAIN BETTER OR WORSE?

☐ YES ☐ NO IF YES, WHAT? _____

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

☐ YES ☐ NO IF YES, WHERE? _____

DO YOU HAVE ANY NUMBNESS/TINGLING IN YOUR BODY? ☐ YES ☐ NO

HAVE YOU HAD AN X☐RAY, MRI, NCS, EMG, OR BLOOD TEST TO HELP DIAGNOSE THIS CONDITION?

☐ YES ☐ NO IF YES, WHERE? _____

HAVE YOU SOUGHT ANY TREATMENTS, MEDICATIONS, SURGERY, OR CARE FOR YOUR CONDITION?

☐ YES ☐ NO IF YES, EXPLAIN _____

HAVE YOU HAD ANY COLON, HEART, LUNG, URINARY, OR CHANGES TO ANY OTHER BODILY FUNCTION?

☐ YES ☐ NO IF YES, EXPLAIN _____

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Medical History

HAVE YOU EVER HAD A CHIROPRACTIC ADJUSTMENT OR ACUPUNCTURE TREATMENT BEFORE?
☐ YES ☐ NO
PLEASE LIST ANY SERIOUS OR CHRONIC MEDICAL ILLNESSES OR CONDITIONS:
_____

PREVIOUS INJURY OR TRAUMA: _____

HAVE YOU EVER BROKEN ANY BONES?
☐ YES ☐ NO
IF YES, WHICH ONES?_____
PLEASE LIST ANY ALLERGIES YOU HAVE:
_____

DO YOU DRINK? ☐ YES ☐ NO
FREQUENCY: _____
DO YOU SMOKE? ☐ YES ☐ NO
FREQUENCY: _____

ARE YOU CURRENTLY TAKING MEDICATION AND/OR SUPPLEMENTS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE A LIST OF MEDICATIONS AND/OR SUPPLEMENTS IN THE TABLE BELOW.

MEDICATION	REASON FOR TAKING

HAVE YOU EVER HAD ANY SURGERY, OPERATION, OR MEDICAL PROCEDURE? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE A LIST OF PROCEDURES IN THE TABLE BELOW.

SURGERY	DATE OF PROCEDURE

Family Health History

IS THERE ANY HEALTH HISTORY OR FAMILY HEALTH HISTORY THAT YOU FEEL IS IMPORTANT TO SHARE?
☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

IMMEDIATE FAMILY MEMBER	CAUSE OF DEATH	AGE

Social & Occupational History

OCCUPATION/ JOB DESCRIPTION: _____
_____

RECREATIONAL ACTIVITIES: _____

I have read the above information & certify it to be true and correct to the best of my knowledge, and hereby authorize Edward Fleming D.C., Indialantic Chiropractic & Acupuncture, Inc. to provide medical care, in accordance with this state's statutes.

_____ _____
Patient/Parent/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.

B) 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.

C) 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.

D) I understand acupuncture may cause swelling, bleeding or bruising. This is normally a temporary situation.

E) I understand if I experience any unusual symptoms following treatment 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 6 YEARS.