

Total Health of Vero Beach New Patient Questionnaire

Patient Information

Please Print

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Seasonal Address _____ City _____ State _____ Zip _____

Male _____ Female _____ Married _____ Single _____ Widowed _____ Divorced _____ Separated _____
Birthdate _____ Home Phone _____ Cell Phone _____ Work Phone _____

Email Address (required) _____
Employer _____ Occupation _____ # years _____
Spouse or Parent Name _____ Birthdate _____ Phone # _____
Emergency Contact _____ Phone # _____ Relation _____
Name of Local Primary Physician _____ May we contact them? _____

How did you hear about us? _____
Did you see our? Web Page? _____ Facebook? _____ Business Sign? _____ Word of mouth? _____

Symptoms

Main complaint _____ When did it start _____
How did it start _____

What activity bothers it most _____ Getting Better/Worse? _____
When is the pain at its worst? (Circle) AM PM Mid Day Sleep Sitting Moving Resting Working
Rate the pain - (0 pain free - 10 unbearable pain) 0 1 2 3 4 5 6 7 8 9 10
Secondary Complaint _____

Other chiropractors? _____ Positive experience? _____ Last Visit? _____
Other type of physician or therapist? _____ Positive experience _____

Health History - Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthmas	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken Pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart Dx
Hepatitis	Hernia	Herniated Disc	Herpes	Hi Cholesterol	Kidney Dx	Liver Dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Chronic Fatigue	Hi Blood Pressure	Fibromyalgia	Other				

Women - How many children? _____ Are you pregnant? _____ Date of Last Menstrual Cycle _____
Nursing? _____ Taking birth control pills? _____

Previous surgeries and dates _____

List all medication your are currently taking _____
What kind of exercise do you do? _____
What supplement do you take? _____
-low much do you smoke per day? _____ Drink per week? _____

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous and can hinder treatment. I authorize this office to release any information pertaining to my treatment to hird party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding money amount owed to this office.

Patient signature _____ Date _____

Patient Name: _____

Date: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in the document. Please ask any questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used as a Doctor of Chiropractic is spinal manipulative therapy. The doctor may use that procedure to treat you. The doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

Be aware that if needed or necessary, the doctor may choose to do an examination of the primary complaint area and/or the whole body to correctly diagnose the condition. Also be aware the doctor may order radiographic studies including x rays.

The material risks inherent in the chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients may feel some stiffness and soreness following the first few days of treatment. The doctor will make a very reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctors attention, it is your responsibility to inform the doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the doctor will check for during the taking of your history and during examination and x ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million and one in five million adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options outside this office.

Other treatment options for your condition may include:

- Self administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgeries

If you choose to use one of the above noted "other treatment options", you should be aware that there are risks and benefits of such options and you may wish to discuss with your primary care physician.

The risks and dangers of attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read [] or have had read to me [] the above explanation of the chiropractic treatment/adjustment and related treatments. I have read the above and will present any questions that I have to the doctor concerning these treatments. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby consent to that treatment.

Dated: _____

Dated: _____

Patients Name

Doctors Name

Signature

Signature

Signature of Parent or Guardian
(if minor)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
At Total Health of Vero Beach

Please check one of the following:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice of Privacy Practices

-OR-

I have declined the opportunity to receive a copy of the Notice of Privacy Practices, but understand it is available to read anytime.

I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Signature of Patient, Parent, Guardian or Patient's legal representative