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?____

Did you see our? Web Page_____ Facebook_____ Business Sign_____ YELP_____ Instagram_____
Word of mouth, who may we thank?_____

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	Arthiritis	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?_____
How 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 third 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 have declined the opportunity to receive a copy of the Notice of Privacy Practices, but understand it is available to read at any time upon request.

-or-

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

I understand that this form will be placed in my patient chart and maintained for 6 years.

Patient Name _____

_____

Signature of Patient/Parent/Guardian or Legal Representative Date

OPTIONAL*

All medical records on file with Total Health Physical Medicine are kept private and confidential. However, Total Health Physical Medicine, PA is allowed to discuss my medical history/treatment with the following individuals: _____ **Initals**

_____

_____

_____

***This info to remain on file for 6 years unless informed otherwise by patient**

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Initial exam = all treatment

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)* | Signature | Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

Name *(PRINT or TYPE)* | Signature | Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDIATE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these that: The undersigned has made, constitued and appointed, and by all these present does herby make, constitute, and appoint TOTAL HEALTH PHYSICAL MEDICINE, P.A. and any of it's duly authorized agents and employees as and need to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders are made payable to the undersigned alone or to the undersigned and the said TOTAL HEALTH PHYSICAL MEDICINE, P.A. at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows TOTAL HEALTH PHYSICAL MEDICINE, P.A., or any of it's agent to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give the said TOTAL HEALTH PHYSICAL MEDICINE, P.A. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatments, services or supplies pertaining to me to release true copies of same to TOTAL HEALTH PHYSICAL MEDICINE, P.A. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm all actions taken by said attorney in accordance with this special power and which said attorney shall do or cause to be done in virtue of these presents.

Release of information: I hereby authorize the medical provider to : furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer, and to obtain copies of my medical records, including but not limited to, documents, records, scans, notes, opinions, X-rays or MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

ASSIGNMENT OF BENEFITS

I,_____Hereby authorize_____
(Name of Insured) (Name of Insurance Carrier)

Payable directly to :
Payable to and mailed directly to:

TOTAL HEALTH PHYSICAL MEDICINE, P.A.
2006 32nd Avenue Ste A
Vero Beach, Fl 32960

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to TOTAL HEALTH PHYSICAL MEDICINE, P.A. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by TOTAL HEALTH PHYSICAL MEDICINE, P.A.

In the event that my insurance company does not pay TOTAL HEALTH PHYSICAL MEDICNE, P.A.'s bills in full and pursuant to the terms of my policy of insurance, I hereby instruct the insurance carrier to set aside all funds in an amount that would be sufficient to pay such bills in full in accordance with the charges submitted. As part of this assignment of benefits, I further instruct the insurance carrier to notify the provider immediatley after any dispute as to the payment so it may preserve and excercise its legal rights. Also, in addition to notifying me and my legal represenative, I instruct the insurace carrier to immediately notify the provider of any scheduled examinations under oath or independent medical examinations. I authorize and instruct the insurance carrier to provide the Provider upon request any and all documents in my file, including but not limited to an up to date and unredacted and complete payout register and medical records. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

IN WITNESS WHEREOF the undersigned have hereunto set their hands,
this _____ day of _____.

_____ _____
Patient's Signature Patient's Name (Please Print)

Notice to Patients:

At Total Health of Vero Beach, our first concern is our patients' wellbeing and restoring them to full function as quickly as possible. For your insurance carrier to continue to cover your treatment with us, you must adhere to a consistent treatment schedule at our office. In our experience over the past twenty years with personal injury cases, there are "red flags" that insurance companies look for to deny a patient's benefits. The number one reason patients are denied continuing treatment for their injuries is missed appointments with our doctors. When there are gaps in treatment dates, or infrequent treatment is noticed by your insurance company, their impression is that you do not have a genuine need for treatment. To avoid being "cut off" from services, treatment must be received in our office at least 3 times per week initially and no less than twice weekly after the first month. We are providing this information in writing to help you avoid any interruption in your recovery from your injuries.

I have read and understand the above recommendations.

Patient name_____

Date of Birth_____

Signature_____

PERSONAL INJURY / WORKER'S COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

_____

_____

What was your position in car? ☐ Driver ☐ Passenger If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your car struck by other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side? ☐ from the rear?

At the time of impact were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window

Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head

Immediately following the accident how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to hospital? ☐ Yes ☐ No

If you went to hospital, when? At time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No

How did you get to hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints: ☐ Yes ☐ No Brace: ☐ Yes ☐ No

Name of Hospital _____

Attended by Dr. _____ Were you x-rayed at hospital? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? ☐ Yes ☐ No See orthopedic doctor? ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

Is your pain constant? ☐ Yes ☐ No Is the pain on and off? ☐ Yes ☐ No Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No

Other _____

Is your pain worse when arising from a chair? ☐ Yes ☐ No Is it made worse by straining? ☐ Yes ☐ No By coughing? ☐ Yes ☐ No

By sneezing? ☐ Yes, ☐ No By straining when moving your bowels? ☐ Yes ☐ No

Do you have any numbness or tingling in your arms? ☐ Yes ☐ No In your hands? ☐ Yes ☐ No In your fingers? ☐ Yes ☐ No

In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No In your toes? ☐ Yes ☐ No

What is your most comfortable position? Sitting ☐ Yes ☐ No Lying on your right side ☐ Yes ☐ No Lying on your left side ☐ Yes ☐ No

Lying on your back ☐ Yes ☐ No On your stomach ☐ Yes ☐ No Standing ☐ Yes ☐ No

Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve your pain? ☐ Heating Pad ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (if you have tried one) help relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in your leg? ☐ Yes ☐ No

In arm? ☐ Yes ☐ No Have you had any change in your bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____