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	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 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 esponsible 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:_____

_____
Patients Name

_____
Signature

_____
Signature of Parent or Guardian
(if minor)

Dated:_____

_____
Doctors Name

_____
Signature

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 them and understand the Notice of Privacy Practices

-or-

___I have declined the opportunity to read them and understand the Notice of Privacy Practices.

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