WELCOME TO OUR CLINIC!

Patient Information

Full Name_____ Date_____ Time_____
What do you prefer to be called?_____ [ ] Male [ ] Female
Home Address_____
City_____State_____Zip_____
Cell Phone_____ Home Phone_____
E-mail_____Date of Birth:_____/_____/_____Age_____
Social Security Number _____Eye Color:_____
Employer_____Occupation_____
Nature of Your Job: [ ] Sitting [ ] Standing [ ] Lifting [ ] Driving [ ] Computer Based [ ] Mechanical
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed
Children_____Ages_____

Primary Care Physician

Dr.'s Name:_____Facility_____
Are you currently being treated for any conditions?_____

Specialty Physicians (Seen in the last five years for any condition)

Dr.'s Name:_____Facility:_____
When:_____ __What conditions were you treated for?_____

Dr.'s Name:_____Facility:_____
When:_____What conditions were you treated for?_____

Emergency Contact

Name:_____Relationship:_____Phone:_____

Insurance Information

Insurance Co:_____ Who is responsible for this account_____
Relationship to Patient:_____ Policy/Member ID #:_____
Group #:_____ Claim # (if applicable):_____

Are you covered by additional insurance: [] Yes [] No

Acceptance As Patient

I understand and agree that the doctors and therapists of Atlantic Chiropractic and Wellness Center have the right to refuse to accept me as a patient at any time before treatment begins. The taking of history and the conduction of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Signature _____ Date_____

As a courtesy a copy of your exam findings can be sent to your Primary Care Physician for a more complete health record.

[ ] Yes, please send a copy of my notes to my PCP [ ] No, please do not send copies of my notes to my PCP

Please give a detailed description of the problem/pain you are currently experiencing:

_____

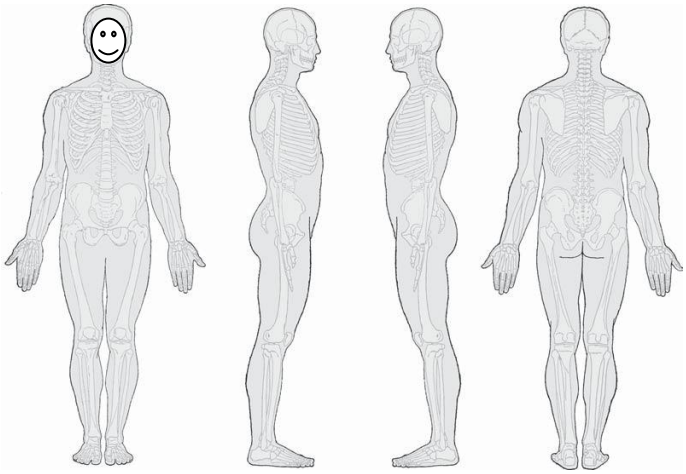
_____

_____

How long have you had this condition? _____ Is it getting worse? □ Yes □ No
Does it bother your (check all that apply): □ Work □ Sleep □ Recreation □ Daily Routine □ Other:_____
What seemed to be the initial cause? _____

Please place <u>CIRCLE</u> the level of your pain on the scale:
(no pain) 0—1—2—3—4—5—6—7—8—9—10 (worst possible pain)

Please mark you area(s) of pain on the figure below



Describe your pain: [] Sharp [] Dull [] Throbbing
[]Aching [] Shooting [] Electrical/Shock-like [] Burning
[] Searing [] Stabbing [] Numbness [] Tingling
[] Weakness [] Cramping [] Stiffness [] Swelling
[] Other _____Does the pain radiate? [] Yes [] No

How often do you experience the pain?
[] Constantly [] Frequently [] Occasionally [] Infrequently

What makes this pain **better**?_____
What makes this pain **worse**?_____

Is the discomfort you experience worse at any time?
[] Morning [] Afternoon [] Evening [] Night while sleeping

Have you **<u>ever</u>** visited another chiropractor? []Yes []No
If Yes, for what reason?_____
When was your last treatment?_____
Was it effective? [] Yes [] No

How long has it been since you really felt good?

_____

If we could help improve 3 things about your health, what would they be?

1._____

2. _____

3. _____

What specific things/activities does your pain prevent you from doing?

_____

_____

Have you <u>ever</u> had any of the following?
(**if yes**, please list year, reason, and outcome)

Surgery_____
Surgery_____
Surgery_____
Surgery_____
Auto Accident_____
Trauma_____
Hospitalization_____
Serious Illness_____
Broken Bones or Fractures_____
Other Injuries_____

_____

_____

Please list any medications you are currently taking.

_____

_____

_____

_____

_____

Have you had any previous imaging done?
[] X-rays [] MRI [] CT [] Vascular [] Ultrasound [] Other

Have you had any previous lab work done?
[] Blood [] Urine [] Stool [] CSF [] Saliva [] Hair [] Skin

When was your last physical examination?_____

Do you have **<u>any other current health issues</u>** or complaints?

_____

_____

Do you have **<u>any</u> <u>previous</u>** health issues, major or minor?

_____

_____

<u>Females</u> Only:
When was your last OB-GYN exam?_____

Are you pregnant? [ ] Yes [ ] No

If Yes, how far along are you?_____

<u>Males</u> Only:
Have you had a prostate exam, and if so, date of last exam?_____ Any Issues?_____

Please Initial_____

How often do you exercise?_____

How many hours of sleep do you get a night?_____

How many glasses of water do you drink per day?____

Do you consume alcohol? [] Yes [] No
How many drinks?_____[] Daily []Weekly []Monthly

How would you describe your diet?
[] Excellent [] Good [] Fair [] Poor

Do you use tobacco? [] Yes [] No
[] Cigarettes [] Cigars [] Snuff [] Dip [] Chew [] Other
How many years?_____How much per day?_____

Do you use recreational or illicit drugs? [] Yes [] No

Are you sexually active? [] Yes [] No
If yes, how many partners? _____

Do you have any hobbies?_____

Please list any nutritional supplements you are taking
_____
_____
_____
Do you have any allergies? [] Yes [] No [] None Known
If Yes, please list. _____
_____

Do you have any Family History of the following?
[] Arthritis [] Asthma [] Alcoholism [] Alzheimer's
[] Cancer [] Depression [] Diabetes [] Drug Addiction
[] Eating Disorder [] Genetic Disorder [] Glaucoma
[] Heart Disease [] Infertility [] Kidney Disease
[] Learning Disability [] Liver Disease [] Mental Illness
[] Mental Retardation [] Migraine Headaches
[] Neurological Disorder (Parkinson's, paralysis)
[] Obesity [] Osteoporosis [] Stroke [] Suicide
[] Other _____

Please check any symptoms you are <u>currently experiencing</u>.

[] Weight Loss [] Weight Gain [] Loss of Appetite
[] Loss of Sleep [] Lethargy [] Loss of Balance
[] Problems Walking [] Problems Sleeping

[] Headaches [] Numbness [] Tingling [] Weakness
[] Radiating/Shooting Pain [] Twitches [] Dizziness

[] High Blood Pressure [] Low Blood Pressure
[] Heart Palpitations [] Varicose Veins [] Easy Bruising
[] Bleeding Disorders [] Anemia [] Blood Clotting Issues
[] Bleed Easily

[] Vision Disturbances [] Change in Sense of Smell
[] Change in Sense of Taste [] Change in Hearing
[] Light Sensitivity [] Buzzing/Ringing in Ears
Do you wear glasses or contacts? [] Yes [] No

[] Nervousness [] Irritability [] Mood Swings
[] Depression [] Memory Loss [] Confusion

On your skin, is there any: [] Open Wounds
[] Bumps or Nodules [] Bites [] Scars [] Red Spots
[] Moles [] Birth Marks [] Discoloration [] Cracks
[] Oozing [] Rough areas [] Dry Areas [] Rashes

[] Increased urinary frequency [] increased urgency
[] Incontinence [] Pain on urination [] Blood in urine
[] Increase/Decrease in amount of urine
[] Noticeable urine odor [] Change in urine color
[] Discharge noted

[] Constipation [] Diarrhea [] Gas [] Bloating
[] Fowl Smelling Gas [] Digestion Pain [] Floating Stool
[] Blood in Stool [] Gastric Reflux/Heart Burn

# of bowel movements do you have a week?_____

[] Difficulty Breathing [] Shortness of Breath
[] Wheezing [] Coughing [] Coughing up blood
[] Coughing up mucus [] Constriction of airways

[] Abdominal masses [] Swelling [] Distension
[] Discomfort [] Unevenness [] Discoloration [] Bulges
[] Tenderness [] Loud Stomach Sounds

[] Stiff Joints [] Tight Muscles [] Tension [] Muscle Spasm [] Muscle Twitching [] Burning Pain

What level of stress are you currently experiencing?
[] None [] Low [] Moderate [] High

Are you [] Right-Handed or [] Left-Handed

Have you had unintentional weight loss or gain of 10 pounds or more in the last 3 months? [] Yes [] No

Is your job associated with potentially harmful chemicals (pesticides, solvents, radioactivity, etc.) or health and/or life threatening activities (fireman, etc)?
[] Yes [] No

What are you looking to get out of your care with us?
[] Pain Relief [] Spinal Correction and Stability
[] Wellness [] Proactive Injury and Illness Prevention
[] All of the above

Please Initial_____

Accident Injury Information

Type of Accident:
[] Auto/Motorcycle [] Work [] Slip and Fall [] Other

Date and Time of Accident:_____

Location of Accident:_____
_____

In your own words, please provide a description of the accident: _____
_____
_____
_____
_____

What is the Year, Make, Model and Color of the vehicle **you were in**? _____

Were there any witnesses? [] Yes [] No

Total number of people in **your** vehicle?_____

Were you: [] Driver [] Passenger
[] Front Seat [] Back Seat
[] Left Side [] Middle [] Right Side

Where you wearing your seatbelt and shoulder harness?
[] Yes [] No

Did the airbag deploy? [] Yes [] No

If you had passengers with you, where were they sitting?
_____

What is the Year, Make, Model and Color of the **other** vehicle?
_____

Number of people in the **other** vehicle?_____

Were you struck from:
[] Behind [] Front [] Left Side [] Right Side

How fast was your vehicle going?_____
How fast was the other vehicle going?_____

To whom have you reported this accident?
[] Auto Insurance [] Employer [] Attorney [] Work Comp.

Were the police notified? [] Yes [] No

Was a report filed? [] Yes [] No

Do you have a copy of the report? [] Yes [] No

Were there any secondary collisions that happened after the initial collision? [] Yes [] No

Were you ticketed? [] Yes []No
Was anyone else ticketed? [] Yes [] No [] Not Sure
If Yes, who?_____

Were paramedics notified? [] Yes [] No
If so, did you receive treatment at the scene? [] Yes [] No

Is your condition since the accident getting:
[] Better [] Staying the Same [] Worse

Were you knocked unconscious? [] Yes [] No

Were you taken to the Hospital or ER? [] Yes [] No
If Yes, by whom? _____
If Yes, when (date and time)?_____
If Yes, which Hospital/ER? _____
Please describe treatment you received:_____
_____
_____

Were the brakes applied before impact? [] Yes [] No

Did you hit **any** part of your body inside the vehicle including the headrest? [] Yes [] No
If Yes, please explain:_____
_____

Were the conditions during the time of the accident
[] Wet [] Dry [] Rainy [] Foggy [] Unclear [] Twilight

When did your symptoms first appear?_____
_____

Please describe your symptoms:_____
_____
_____
_____

Did you have any physical complaints before the accident?_____
_____

Have you been treated by **any** other health care providers since the accident?_____
_____
Have you lost time from work as a result of this accident?
[] Yes [] No
If Yes, please list dates:_____

What was the $ amount of damage to your vehicle?_____

Was your vehicle towed after the accident? [] Yes [] No

Was your vehicle drivable after the accident? [] Yes [] No

Did you anticipate and/or brace for impact? [] Yes [] No

At impact, were you looking at an outside door mirror?
[] Yes [] No If Yes, [] Right [] Left

Were you looking up at the rear-view mirror? [] Yes [] No

In relation to the back of your head, was your headrest:
[] Below Your Head
[] Above Your Head [] Directly Behind Your Head

Is there anything else you would like to tell us about the accident? _____
_____
_____
_____

Please Initial_____

CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

[ ] Headache [ ] Irritability [ ] Numbness in Fingers or Toes [ ] Face Flushed [ ] Cold Feet [ ] Cold Hands
[ ] Neck Pain [ ] Chest Pain [ ] Shortness of Breath [ ] Buzzing or Ringing in Ears [ ] Neck Stiff [ ] Dizziness
[ ] Fatigue [ ] Loss of Balance [ ] Stomach Pain or Upset Stomach [ ] Sleep Problems
[ ] Head Seems Heavy [ ] Depression [ ] Fainting [ ] Back Pain [ ] Pins & Needles in Arms or Legs
[ ] Lights Bother Eyes [ ] Loss of Smell [ ] Constipation [ ] Loss of Range of Motion [ ] Nervousness
[ ] Loss of Memory [ ] Loss of Taste [ ] Cold Sweats [ ] Tension [ ] Diarrhea [ ] Fever [ ] Head Seems Foggy
[ ] Loss of Bowel or Bladder Control [ ] Radiating Pain Into Shoulders, Arms, Hands, Hips, Knees, Buttocks, Feet
[ ] Other: _____

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.

If an activity does not cause pain or if pain does not affect an activity, leave box blank.

[1] This activity causes some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

[ ] bathing/showering [ ] brushing teeth [ ] putting on shoes and/or socks [ ] eating [ ] doing laundry
[ ] grooming hair [ ] making the bed [ ] putting on pants [ ] washing dishes [ ] going to toilet
[ ] washing face [ ] putting on shirt [ ] cooking [ ] taking out trash

Physical Activities

[ ] standing [ ] walking [ ] reaching [ ] bending right [ ] twisting right [ ] laying on your back and/or side
[ ] sitting [ ] squatting [ ] bending forward [ ] bending left [ ] twisting left
[ ] reclining [ ] kneeling [ ] bending back [ ] looking left [ ] looking right

Functional Activities

[ ] carrying small objects [ ] lifting weights off table [ ] pushing/pulling while standing
[ ] carrying large objects [ ] climbing stairs/incline [ ] exercising upper body [ ] caring for children or a pet
[ ] carrying briefcase/purse [ ] pushing/pulling while seated [ ] exercising lower body
[ ] lifting object off floor [ ] getting in/out of vehicle [ ] coughing [ ] sneezing [ ] having a bowel movement

Social and Recreational Activities

[ ] bowling [ ] jogging [ ] swimming [ ] golfing [ ] dancing
[ ] biking [ ] hunting/fishing [ ] gardening [ ] competitive sports
[ ] walking [ ] horse riding [ ] other: _____

Difficulties with Traveling

[ ] driving in car [ ] driving for long periods of time [ ] getting in or out of a vehicle
[ ] riding as passenger [ ] riding as passenger for long periods of time

Other activities

Use this scale for the following activities:
[1] This activity is slightly affected by my condition
[2] This activity is moderately affected by my condition
[3] This activity is severely affected by my condition
[4] I cannot perform this activity due to my condition

[ ] concentrating [ ] listening [ ] reading [ ] studying [ ] writing [ ] using computer
[ ] sleeping [ ] sexual relations

Name_____Signature_____ Date_____

HIPAA Notice of Privacy Practices Statement

How We Collect Information About You: Atlantic Chiropractic and Wellness Center (ACWC) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.
We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between IHSN and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,
If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.atlanticchirofl.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of ACWC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.
Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.
You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

Assignment of Benefits

I authorize payment of medical benefits to Atlantic Health Solutions, Inc. Atlantic Chiropractic & Wellness Center will file my claim for me, and re-file if necessary, but will not assume responsibility for collecting in my insurance claim or negotiating settlement on a disputed claim. If my insurance does not pay my claim, I understand that it will be my responsibility to pay.

I authorize release of any medical or other information necessary to process claims. I request payment of any benefits be made to Atlantic Chiropractic and Wellness Center for any and all services rendered.

_____
Print Name

_____
Signature Date

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, acupuncture, massage therapy, nutrition supplements and therapy, and diagnostic x-rays or other imaging, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below, and/or their preceptor/intern, and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, headaches, strokes, dislocations and sprains, though the possibility of these risks/complications is rare. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal and other joint dysfunction and as such, is oriented toward improvement of spinal or other joint function relative to range of motion, muscular and neurological aspects, all as they relate to normal function and activities of daily living. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. Correction of this joint dysfunction is called an adjustment, involving a quick, precise force directed over a short distance to a specific bone, soft tissue or joint. There are a number of different techniques utilized to deliver the adjustments, including some specially designed equipment.

I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

In addition to adjustments, treatments may also include, but are not limited to: ice, heat, ultrasound, electric muscle stimulation, cold laser therapy, mechanical or manual traction, therapeutic taping, soft tissue mobilization or treatment, massage therapy, analgesic therapy, nutrition therapy, acupuncture, pressure point therapy, balance training, therapeutic exercises, stretches, vibration therapy, nutritional and diet recommendations, and other rehabilitative procedures.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect any contraindications to standard chiropractic treatment.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to any of the above-named procedures as treatment as deemed necessary by the doctor. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signature

_____ _____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Relation to Patient

_____

Doctor Signature Date